HEALTH AND SENIOR SERVICES

DIVISION OF SENIOR BENEFITS AND UTILIZATION MANAGEMENT

Long Term Care Services

Proposed Readoption and Recodification with Amendments: N.J.A.C. 10:63 as N.J.A.C. 8:85

Proposed Repeals: N.J.A.C. 10:63-1.8, 1.11, 3.22, 3.23 and 3.24 and Appendices A through Q

Proposed Repeals and New Rules: N.J.A.C. 8:85-1.8 and Appendices A through N, P and Q

Authorized By: Clifton R. Lacy, M.D., Commissioner, Department of Health and Senior Services

Authority: N.J.S.A. 30:4D-6(a)(4)(a), b(14), 30:4D-7, 7(a), (b), and (c); 30:4D-12; 30:4D-6.7, 6.8; 42 U.S.C. §1396a(a)(13)(A); 42 U.S.C. §1396r; and Executive Reorganization Plan 001-1996.

Calendar Reference: See Summary below for explanation of exception to the calendar requirement.

Proposal Number: PRN 2004-361

Submit written comments by December 17, 2004 to:

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A copy of the proposal is available for review at all offices of the Area Agencies on Aging, which are situated in all 21 counties.

The agency proposal follows:

Summary

Responsibility for the Title XIX (Medicaid) nursing facility program was transferred from the Department of Human Services, Division of Medical Assistance and Health Services, to the Department of Health and Senior Services pursuant to Executive Reorganization Plan No. 001-1996.

The Department of Health and Senior Services ("Department" or "DHSS") is proposing to readopt N.J.A.C. 10:63 with amendments, which is the Long-Term Care Services Manual, and recodify it as N.J.A.C. 8:85. N.J.A.C. 10:63 pertains to the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible individuals in Nursing Facilities (NFs). This proposal also includes amendments reflecting departmental and divisional name changes. It also corrects other internal cross-references and amends selected rules within that chapter. Pursuant to N.J.S.A. 52:14B-5.1c, N.J.A.C. 10:63 will expire on March 23, 2005.

Three sections of the current rules are being proposed for repeal. N.J.A.C. 10:63-3.22, Transitional relief for salary region adjustment, State Fiscal Year 1993; N.J.A.C. 10:63-3.23, Transitional relief for salary region adjustment, State Fiscal Year 1994; and N.J.A.C. 10:63-3.24, Transitional relief for salary region adjustment, State Fiscal Year 1995 are being repealed. The original purpose of these sections was to provide transitional relief for those nursing facilities most negatively impacted during the

State fiscal year by the adjustment to a single Statewide salary region. These sections are no longer needed because they are no longer effective.

Throughout this proposal, amendments have been made to the administrative names and addresses related to the Medicaid nursing facility program in recognition of changes in responsibilities. These include changes from the "Department of Human Services" to the "Department of Health and Senior Services," from the "Division of Medical Assistance and Health Services" to the "Division of Senior Benefits and Utilization Management," and from the "Medicaid District Office (MDO)" to the "Long Term Care Field Office (LTCFO)." Also throughout this chapter, the term "recipient" has been changed to "beneficiary," and references to "regional staff nurses" and "social workers" have been changed to "professional staff designated by the Department."

Subchapter 1, General Provisions, is concerned with outlining the process and requirements for eligibility for Medicaid patients in nursing facilities (NFs).

Subchapter 2, Nursing Facilities Services, concerns services NFs must provide or make available to Medicaid patients.

Subchapter 3, Cost Study, Rate Review Guidelines and Reporting System for Long-Term care, contains the specific Medicaid reimbursement methodology.

Subchapter 4, Audit, outlines the process for DHSS, or its agent, to audit Medicaid participating NFs.

The contents of the rules proposed for readoption and recodification, proposed amendments and repeals being proposed follow.

Subchapter 1. General Provisions

N.J.A.C. 10:63-1.1, Scope, will be recodified with amendments as N.J.A.C. 8:85-1.1. As administration of the Medicaid programs concerning psychiatric and/or developmental disability facilities or services has remained with the Department of Human Services, the recodified N.J.A.C. 8:85-1.1 now clarifies that rules for these types of facilities are addressed elsewhere in the appropriate chapters of Title 10.

N.J.A.C. 10:63-1.2, Definitions, will be recodified with amendments as N.J.A.C. 8:85-1.2. The definition of "Department of Health (DOH)" has been amended to "Department of Health and Senior Services (Department or DHSS)." New definitions are being proposed for the following terms: "beds or licensed beds," "beneficiary," "county welfare agency (CWA)," "Department of Human Services," "Division of Medical Assistance and Health Services," "material fact," "minimum data set (MDS) 2.0 or most current version", "Ombudsman" and "professional staff designated by the Department." The case management process has been renamed "care management," and reference to the "Division of Medical Assistance and Health Services Medical Social Care Specialist" has been replaced with "professional staff designated by the Department." The terms "Medical Evaluation Team," "Medical Social Care Specialist (MSCS)," and "Regional Staff Nurse (RSN)," and their corresponding definitions have been deleted throughout this chapter, as these terms are specific to the Division of Medical Assistance and Health Services in the Department of Human Services. The classification portion of the standardized resident assessment (SRA), Section Q, formerly Appendix O, was removed from the Minimum Data Set (MDS) on May 1, 2000; therefore, the definition of "Section Q" is being deleted and Appendix O repealed. The

other Appendices to N.J.A.C. 10:63 are repealed and substantively similar Appendices of the Department are proposed.

N.J.A.C. 10:63-1.3, Program participation, will be recodified with amendments as N.J.A.C. 8:85-1.3 and will be amended to clarify that a nursing facility (NF) must comply with certain requirements in order to participate in the New Jersey Medicaid program. N.J.A.C. 8:85-1.3(a)6 has been amended to explicitly state that a provider must accept the Medicaid program's reimbursements as payment in full for all covered services. (See 42 CFR §447.15.) This amendment renders reference to N.J.A.C. 10:49 of the Department of Human Services unnecessary and this cross-reference has been deleted. In addition, the names of forms that are used in order to be approved for participation as a NF provider by the New Jersey Medicaid program have been revised, and a reference as to where to find them on the Internet has been added in addition to the Appendices reproduced here.

N.J.A.C. 10:63-1.4, Private pay, will be recodified without amendments as N.J.A.C. 8:85-1.4.

N.J.A.C. 10:63-1.5, Occupancy level, will be recodified with amendments as N.J.A.C. 8:85-1.5 and will be amended to include the term "Medicaid" in the section heading in order to make clear the fact that this subchapter specifically address the Medicaid program administered by the Department.

N.J.A.C. 10:63-1.6, Termination of a NF provider agreement, will be recodified with amendments as N.J.A.C. 8:85-1.6 and will be amended to include the term "Medicaid" in the section heading in order clarify that the subject of this subchapter is the provider agreement with the Medicaid program administered by the Department.

N.J.A.C. 10:63-1.7, Administrative appeal of denial, termination or non-renewal of NF certification or Medicaid Provider Agreement, will be recodified as N.J.A.C. 8:85-1.7 with technical amendments.

N.J.A.C. 10:63-1.8, Admission, transfer and readmission; general, and 1.11, NF authorization process, will be repealed and their contents consolidated into one section, new N.J.A.C. 8:85-1.8. The Department has determined that the current rules at N.J.A.C. 10:63-1.8 and 1.11 overlap to the extent that a significant improvement in readability and usability could be realized through a consolidation of the two sections into a single section at N.J.A.C. 8:85-1.8. New N.J.A.C. 8:85-1.8 also includes new provisions at proposed N.J.A.C. 8:85-1.8(a)1 through 3 which address pre-admission screening, admission, and authorization. Reporting of routine Medicaid admissions and discharges on the MCNH 33 form has been discontinued. Therefore, the proposed N.J.A.C. 8:85-1.8 does not include this requirement, currently at N.J.A.C. 10:63-1.8(l). As a result of the proposed consolidation of N.J.A.C. 10:63-1.8 and 1.11 into one section at N.J.A.C. 8:85-1.8, N.J.A.C. 8:85-1.11 is proposed as a reserved section.

Effective October 15, 1997, Annual Resident Review (ARRs) are no longer required. Therefore, the DHSS is proposing to remove this requirement in the current N.J.A.C. 10:63-1.8(c) from the proposed N.J.A.C. 8:85-1.8. The reviews of mentally ill and mentally retarded individuals are still conducted in the event of a significant change in condition pursuant to 42 CFR §483.130.

The mandatory use of the PA-4 form has been eliminated in the case of nursing facilities requesting pre-admission screening of an individual currently residing in a

Medicaid-participating NF, in order to reduce the amount of time and paperwork required by the authorization process.

The procedure concerning continued stay/alternate care is addressed in the proposed N.J.A.C. 8:85-1.8(h).

Proposed N.J.A.C. 8:85-1.8(k) clarifies the meaning of the phrase “discharge, death, transfer and ineligibility,” which appears in the current N.J.A.C. 10:63-1.11(h).

N.J.A.C. 10:63-1.9, Waiting list, will be recodified with amendments as N.J.A.C. 8:85-1.9. N.J.A.C. 10:63-1.9(a), regarding establishment of a waiting list, currently specifies events and situations which represent possible exceptions to the strict utilization of the waiting list. The proposed recodification with amendments at N.J.A.C. 8:85-1.9(a) adds transfer from another nursing facility to this listing.

N.J.A.C. 10:63-1.10, Involuntary transfer initiated by the facility, will be recodified with amendments as N.J.A.C. 8:85-1.10 and will be amended to include a clarification of the procedure for an involuntary transfer at recodified N.J.A.C. 8:85-1.10(g)2. If the Long Term Care Field Office (LTCFO) determines that an involuntary transfer is appropriate, the beneficiary and/or the beneficiary’s authorized representative will be given 30 days written notice by the nursing facility. The nursing facility will forward a copy of the notice to the LTCFO. The beneficiary and/or the beneficiary’s authorized representative will be advised of the right to a hearing and will be supplied with the address of where to send the request for a hearing. If the LTCFO determines that a situation or emergency exists, the transfer will take place immediately and the beneficiary or the beneficiary’s authorized representative will be given 30 days after the transfer to request a hearing.

N.J.A.C. 10:63-1.12, Clinical audit, will be recodified as N.J.A.C. 8:85-1.12, with technical amendments.

N.J.A.C. 10:63-1.13, Clinical and related records, will be recodified with amendments as N.J.A.C. 8:85-1.13. The current rule at N.J.A.C. 10:63-1.13(b) requires clinical records to be available at the nurse's station of the nursing facility for review by DHSS staff. The proposed recodification with amendments at N.J.A.C. 8:85-1.13(a) adds the Health Services Delivery Plan (HSDP) approval letter and, if applicable, the Pre-admission screening and annual resident review (PASARR) to be available for DHSS review.

N.J.A.C. 10:63-1.14, Absence from facility due to hospital admission or therapeutic leave; bed reserve, will be recodified with amendments as N.J.A.C. 8:85-1.14. Currently, N.J.A.C. 10:63-1.14 requires that a nursing facility maintain a bed for a Medicaid resident discharged to a general or psychiatric hospital for up to 10 days. The New Jersey Medicaid program will reimburse the nursing facility for reserving the Medicaid resident's bed, for a period not to exceed 10 days, at 90 percent of the rate the NF received prior to the transfer to the hospital. That bed must remain empty and not be occupied by another individual during the bed reserve period unless it is authorized by the Department. When a Medicaid resident is discharged from a general or psychiatric hospital back to the nursing facility and is then transferred back to the general or psychiatric hospital, Medicaid will not reimburse the NF for an additional 10-day bedhold unless the Medicaid resident remained in the NF for twenty-four hours prior to readmission to the hospital. Two additional provisions regarding bedhold have been added to the proposed recodification with amendments at N.J.A.C. 8:85-1.14(a)2ii and

iii. Recodified N.J.A.C. 8:85-1.14(a)2ii provides that the Medicaid program will not reimburse the NF for bedhold if a third-party insurer is making the NF per diem payment for a "Medicaid eligible beneficiary." Recodified N.J.A.C. 8:85-1.14(a)2iii provides that when a Medicaid beneficiary is transferred back to the NF and then readmitted to a general or psychiatric hospital, the NF will not be reimbursed for an additional 10-day bed reserve if the Medicaid beneficiary was not in the NF for at least 24 hours prior to being readmitted to the hospital. The Department is proposing these regulatory amendments in order to document and further clarify these long-standing policies.

N.J.A.C. 10:63-1.15, Complaints, will be recodified as N.J.A.C. 8:85-1.15, with technical amendments.

N.J.A.C. 10:63-1.16, Utilization of resident's income for cost of care in the NF and for PNA, will be recodified with amendments as N.J.A.C. 8:85-1.16. Nursing facilities are required to collect income from the beneficiary which is needed to offset the Medicaid payment only after provisions for the beneficiary's Personal Needs Allowance (PNA) and maintenance of the spouse and/or dependent children are made. The Department is proposing amendments to this section in order to facilitate the application of this requirement. Text at N.J.A.C. 10:63-1.16(b)2 was inadvertently omitted when the Long Term Care Services Manual was reorganized upon readoption in 1995. Accordingly, the omitted language is being added to the proposed recodification with amendments at N.J.A.C. 8:85-1.16(b)2. The language states that once the NF initiates billing for a Medicaid beneficiary, that beneficiary will remain a Medicaid beneficiary for the full term of stay in the NF (until death or physician discharge), unless the patient loses eligibility or benefits are terminated by request. The term "imprest" has been

removed from the term “imprest fund” existing rule at N.J.A.C. 10:63-1.16(f)6 recodified with amendments to N.J.A.C. 8:85-1.16(f)6 in order to avert confusion.

N.J.A.C. 10:63-1.17, Residents rights, and 1.18, Medicaid/Medicare, will be recodified as N.J.A.C. 8:85-1.17 and 1.18, respectively, with technical amendments.

Subchapter 2. Nursing Facilities Services

N.J.A.C. 10:63-2.1, Nursing facility services; eligibility, will be recodified with amendments as N.J.A.C. 8:85-2.1 and will be amended to clarify the Department’s definition of activities of daily living (ADLs). The current N.J.A.C. 10:63-2.1(a)1 states that NF beneficiaries are dependent in several activities of daily living. The proposed recodification with amendments at N.J.A.C. 8:85-2.1(a)1 lists the specific ADLs: bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating.

N.J.A.C. 10:63-2.2, Delivery of nursing services, will be recodified with amendments as N.J.A.C. 8:85-2.2. As previously mentioned, the classification portion of the standardized resident assessment (SRA), Section Q, was removed from the Minimum Data Set (MDS). Therefore, the reference to Section Q has been deleted. The list of nursing services at the current N.J.A.C. 10:63-2.2(a), now recodified with amendments to N.J.A.C. 8:85-2.2(a) have been renumbered to appear in the same order as N.J.A.C. 8:85-2.2(f).

The Department is proposing revisions to the current N.J.A.C. 10:63-2.2(g), recodified with amendments as N.J.A.C. 8:85-2.2(f). The definition of “tube feeding” has been amended to be more consistent with the Medicare definition, which relates to the tube feeding providing 51 percent of the nutrition for the individual and a specific amount of fluid intake. The current definition does not include a specific percentage of

nutrition to come from the tube feeding, so the amended definition includes it. “Deep suctioning” was added to the definition of tracheostomy; and “flushing and dressing of the central venous lines” was added to intravenous therapy to clarify the definitions so the provider does not claim another add-on service to address the needs.

The use of oxygen therapy in current N.J.A.C. 10:63-2.2(g)3, now proposed for recodification with amendments as N.J.A.C. 8:85-2.2(f)3, has been amended to clarify the Department’s position on the use of oxygen. The new explanation reinforces the nursing duties involved with this add-on service.

Current N.J.A.C. 10:63-2.2(g)6, now proposed for recodification with amendments as N.J.A.C. 8:85-2.2(f)6, has been amended to replace the term “respirator use” which includes mechanical ventilation, with the term “respiratory services” as a regular NF does not provide “respirator use” service. The proposed revised term “respiratory services” reflects nursing duties involved with the respiratory care in a NF like aerosol therapy, CPAP, and BiPAP.

N.J.A.C. 10:63-2.3, Physician services; 2.4, Rehabilitative services; 2.5, Resident activities; 2.6, Social services; 2.7, Pharmaceutical services; general; 2.8, Consultations and referrals for examination and treatment; 2.9, Mental health services; 2.10, Dental services; 2.11, Podiatry services; 2.12, Chiropractic services; 2.13, Vision care services; 2.14, Laboratory; X-ray; portable X-ray and other diagnostic services; 2.15, Medical supplies and equipment; 2.16, Consultant services; general; and 2.17, Transportation services, will be recodified as N.J.A.C. 8:85-2.3 through 2.17, respectively, with technical amendments.

N.J.A.C. 10:63-2.18, Bed and board, will be recodified with amendments as N.J.A.C. 8:85-2.18 and will be amended to include the term “semiprivate” so as to clarify the kind of rooms that are provided.

N.J.A.C. 10:63-2.19, Housekeeping and maintenance services, will be recodified as N.J.A.C. 8:85-2.19, without amendment.

N.J.A.C. 10:63-2.20, Non-covered services, will be recodified with amendments as N.J.A.C. 8:85-2.20 and will be amended to clarify the intent to include medical/social day care as being among the non-covered services in nursing facilities.

N.J.A.C. 10:63-2.21, Special care nursing facility (SCNF) will be recodified with amendments as N.J.A.C. 8:85-2.21. The proposed recodification with amendments at N.J.A.C. 8:85-2.21(a) adds a provision at N.J.A.C. 8:85-2.21(a)2 that prevents a SCNF from receiving reimbursement from the Medicaid program from increasing its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department. This is an attempt to prevent facilities from adding expensive SCNF beds without permission or Certificate of Need Approval. The current N.J.A.C. 10:63-2.21(c), now being proposed for recodification with amendments to N.J.A.C. 8:85-2.21(c), specifies that the individual’s progress and overall response to the therapeutic regimen will determine their length of stay. This clarifies that the individual will not stay in the SCNF indefinitely. The concept of the SCNF is a short-term placement for intensive care, and then to move to a less intense setting or facility. Current N.J.A.C. 10:63-2.21(e)2iii, now being recodified with amendments to N.J.A.C. 8:85-2.21(e)2iii, is being amended to clarify that a SCNF that is an identifiable unit within a conventional nursing home, must calculate the nurse staffing level separate and

apart from the staffing level of the conventional beds. The proposed recodification with amendments at N.J.A.C. 8:85-2.21(e)2iv clarifies that the seven add-on services available to conventional NF units are not an add-on for the SCNF unit, because the SCNF unit has a much higher RN staff and can provide the needed care to the population in the SCNF. The current N.J.A.C. 10:63-2.21(e)7iv now being proposed for recodification with amendments to N.J.A.C. 8:85-2.21(h)7iv (8) and (9) gives a list of needs that a non-ventilator dependent child or adult must exhibit in order to receive medically prescribed respiratory therapy. The proposed recodification with amendments at N.J.A.C. 8:85-2.21(h)7iv(8) and (9) adds assessment, intervention and evaluation by a registered professional nurse and protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by a physician or advanced practice nurse to the list of needs of a non-ventilator dependent child or adult.

Subchapter 3. Cost Report, Rate Review Guidelines and Reporting System for Long-Term Care Facilities

N.J.A.C. 10:63-3.1, Purpose and scope, will be recodified as N.J.A.C. 8:85-3.1, with technical amendments.

N.J.A.C. 10:63-3.2, Timing, will be recodified with amendments as N.J.A.C. 8:85-3.2 and the heading and first sentence of the section will be amended to clarify that this section refers to the preparation and submission of cost reports.

N.J.A.C. 10:63, Rate components; 3.4, Equalized costs; 3.5, Raw food costs; 3.6 General services expenses; 3.7, Property operating expenses; and 3.8, Special amortization, will be recodified as N.J.A.C. 8:85-3.3 through 3.8, respectively, with technical amendments.

Current N.J.A.C. 10:63-3.9, now being proposed for recodification with amendments as N.J.A.C. 8:85-3.9, was previously proposed for amendment in the New Jersey Register at 35 N.J.R. 378(a). The New Jersey Hospital Association submitted a comment in support of the amendment. The time for adoption of the proposed amendment expired, so it is being included in this current proposal for amendment. Nursing facilities (NFs) are required to report clinical data regarding the number of patients that receive additional nursing services for specific conditions or acuities. This clinical data is included in the reimbursement methodology used to calculate per diem rates of reimbursement. Currently, the NFs report the number of clients that received additional nursing services based on patient acuities for Medicaid and non-Medicaid patients on the Turn Around Document (TAD) that they submit to the fiscal agent (Unisys). Patients billed as Medicaid on the TAD are sometimes incorrectly dropped from the case mix patient classification total if, for example, a question of eligibility should arise and the case is pending. As a result, the Department receives numerous appeals. The Department is proposing to use the acuity totals reported on cost reports for the calculation of the minimum nursing requirements rather than acuities reported on the TAD.

N.J.A.C. 10:63-3.10, Property-capital costs; 3.11, Building and fixed equipment; 3.12, Land 3.13, Moveable equipment; 3.14, Maintenance and replacements; 3.15, Property insurance; 3.16, Target occupancy levels; 3.17, Restricted funds; 3.18, Adjustments to base period data; 3.19, Inflation; and 3.20, Total rates, will be recodified as N.J.A.C. 8:85-3.10 through 3.20 with technical amendments.

N.J.A.C. 10:63-3.21, Appeals process, will be recodified with amendments as N.J.A.C. 8:85-3.21 and will be amended to combine three separate filing actions (see current N.J.A.C. 10:63-3.21(a)1i through iii) by the nursing facility into a single filing action (see recodified N.J.A.C. 8:85-3.21(a)1i). The response time by the NF to submit the appeal has been reduced from a total of 80 days for three separate filing actions to 60 days for the single action. An amendment was also added to make clear that no issues other than the specific issues identified in the original Level I appeal will be heard at the Level II appeal.

As previously discussed, N.J.A.C. 10:63-3.22, 3.23 and 3.24 are proposed for repeal.

N.J.A.C. 10:63-3.25, Transfer of ownership, will be recodified as N.J.A.C. 10:63-3.22, with technical amendments.

Subchapter 4. Audit

N.J.A.C. 10:63-4.1, Audit cycle; 4.2, Audits; and 4.3, Final audited rate calculation, will be recodified as N.J.A.C. 8:85-4.1, 4.2 and 4.3, respectively, with technical amendments.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirements, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The rules proposed for readoption and the proposed recodification, amendments and repeals should have a positive impact on applicants for and beneficiaries of Long-

Term Care services related to Medicaid. Amending the rules will ensure that the rules clearly identify eligibility standards for Long-Term Care related Medicaid beneficiaries.

At the present time, there are approximately 321 nursing facilities providing services on a monthly basis to approximately 28,500 Medicaid beneficiaries in New Jersey.

The State should benefit from the proposed readoption and the proposed recodification, amendments and repeals because these rules allow the Department to continue these programs in accordance with current standards. They ensure the continuation of health care benefits to eligible beneficiaries and continued adequate financial reimbursement to providers, which should have a positive impact on the health and social welfare of the citizens in the State of New Jersey.

Economic Impact

The rules proposed for readoption and the proposed recodification, amendments and repeals should not create a change in the economic impact of the program because the Department will continue to cover the same eligible individuals. There are approximately 28,500 Medicaid beneficiaries cared for in 321 licensed NFs. While the number of beneficiaries cared for in NFs will decline, the overall total payments are not expected to change as a result of the rules proposed for readoption with amendments.

The proposed amendment at recodified N.J.A.C. 8:85-3.9(b)1i regarding patient routine care replaces the source of reporting clinical data from the records of the fiscal intermediary to the records of the facility. Since the facility data will now more accurately match the costs reported with the clinical conditions of patients, the proposed

amendment will minimize disputes or appeals and, consequently, reduce the administrative costs of filing and processing appeals.

Federal Standards Statement

The rules proposed for readoption and recodification with amendments do not impose requirements in excess of Federal requirements at 42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. 1396r. Proposed new N.J.A.C. 8:85-1.8 incorporates by reference, as amended and supplemented, the pre-admission screening and resident review criteria at 42 C.F.R. § 483.102. The rule meets, but does not exceed this Federal requirement. Therefore, a Federal Standards analysis is not required.

Nursing facility reimbursement is governed by Federal law at 42 U.S.C. §1396a(a)(13)(A) which requires that the methodologies underlying the establishment of the rates, and justification for the proposed rates, be published so as to allow providers, beneficiaries, their representatives, and other concerned State residents the opportunity to comment. This proposal is intended to satisfy the statutory requirement 42 U.S.C. §1396a(a)(13)(A).

Jobs Impact

The rules proposed for readoption and recodification with amendments will not alter nursing facility rules regarding staffing. Thus, there should be no gain or loss of jobs in the State as a result of these rules proposed for readoption with amendments.

Agriculture Industry Impact

The rules proposed for readoption and recodification with amendments will have no impact on the agriculture industry.

Regulatory Flexibility Statement

The rules proposed for readoption and the proposed recodification, amendments and repeals impose reporting, record keeping and compliance requirements on New Jersey licensed NFs, some of which may be small businesses within the meaning of the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

At the present time, providers are required by law to maintain records sufficient to fully document the name of the resident being treated, dates and nature of services, etc. (see N.J.S.A. 30:4D-12). These documentation requirements include the preparation and submission of cost reports to the State, which are subsequently used as a basis for establishing a nursing facility's per diem rate of reimbursement. The reporting procedures are identical for all facilities.

The proposed amendments at current N.J.A.C. 10:63-3.9, recodified to N.J.A.C. 8:85-3.9 would create a minor change in the reporting process. Acuity information that had been previously reported on the fiscal agent billing document would now be reported on the cost report. In amending these rules, the Department is proposing the elimination of the mandatory use of forms, which due to other procedural changes are no longer necessary. These deletions are intended to save time and resources.

Small businesses may be required to retain the services of professionals such as accountants, attorneys and medical professionals. These added cost factors are reflected in the reimbursement rates for the services that are provided.

Since providing health care services to citizens of the state of New Jersey is a highly regulated industry, the Department has provided no lesser or differing standards for small businesses because it has determined that the rules proposed for readoption and the proposed recodification, amendments and repeals are the minimum necessary to protect the health, safety and welfare of the patient population.

Smart Growth Impact

The rules proposed for readoption and recodification with amendments will have no impact on the achievement of smart growth or implementation of the State Development and Redevelopment Plan.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:63.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 10:63-1.8, 1.11, 3.22, 3.23 and 3.24 and Appendices A through Q.

Full text of the proposed amendments and new rule follow (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

[10:63]**8:85**-1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF)

and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. [Although the scope of the Long-Term Care Services chapter encompasses other long-term care facilities such as governmental psychiatric hospitals, inpatient psychiatric services/programs for the under 21 (residential treatment centers) and intermediate care facilities/mentally retarded (ICF/MRs), the]**The** following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement [applies to all the above cited long-term care facilities] **continues to apply to all government psychiatric hospitals, inpatient psychiatric services and programs in long term care facilities. These other types of facilities are addressed for regulatory and administrative matters in the appropriate chapters elsewhere in Title 10 of the New Jersey Administrative Code**.

[10:63]**8:85**-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

…

"Beds" or "licensed beds" means, with reference to a facility, the total number of beds on the facility's certificate/license.

"Beneficiary " means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

"[Case]**Care** management" means a process by which [the Division of Medical Assistance and Health Services Medical Social Care Specialist] **professional staff designated by the Department of Health and Senior Services** monitor[s] the provision of nursing facility care to assure timely and appropriate provider responses to changes in care needs and delivery of coordinated services.

…

"County welfare agency (CWA)" means that agency of county government with the responsibility to determine income eligibility for public assistance programs including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. The CWA may be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department of Health **and Senior Services**" [(DOH)] **(Department or DHSS)** means the New Jersey State Department of Health **and Senior Services**.

"Department of Human Services" (DHS) means the New Jersey State Department of Human Services.

"Division of Developmental Disabilities" (DDD) means **the New Jersey State Department of Human Services,** Division of Developmental Disabilities [within the New Jersey State Department of Human Services].

"Division of Medical Assistance and Health Services" (DMAHS) means the New Jersey State Department of Human Services, Division of Medical Assistance and Health Services.

"Division of Mental Health [and Hospitals (DMH & H)] **Services" (DMHS)** means the **New Jersey State Department of Human Services,** Division of Mental Health [and Hospitals] **Services** [within the New Jersey State Department of Human Services].

"Health Services Delivery Plan (HSDP)" means [an initial] **a** plan of care prepared by [the Regional Staff Nurse] **professional staff designated by the Department** during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

…

"Material fact" means any reported costs, statistics, data or supporting documentation submitted to the Medicaid program for the purpose of receiving any benefit, regardless of whether any benefit is ultimately received.

…

["Medical evaluation team (MET)" means a team of Medicaid professionals consisting of a physician consultant, a regional staff nurse (RSN), a regional pharmaceutical

consultant, a Medical Social Care Specialist I (MSCS I) and a Medical Social Care Specialist II (MSCS II) who are assigned to the Medicaid District Office (MDO). A MET has the responsibility to review medical, nursing and social information as well as any other supporting data in order to evaluate the need for long-term care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of service. Members of the MET may review each recipient or potential recipient as individual team members or may perform the review as a multidisciplinary team.

"Medical social care specialist (MSCS)" means a social worker employed by the Division of Medical Assistance and Health Services who performs case management as required by N.J.A.C. 10:63.]

…

"Minimum Data Set (MDS) version 2.0 or most current version" of the Resident Assessment Instrument (RAI) means the Standardized Resident Assessment (SRA) instrument required to be completed on all residents in Medicare and/or Medicaid certified long term care facilities on or after June 22, 1998. The MDS assessment identifies the individual NF resident's nursing and care needs.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health **and Senior Services** for participation in

Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid [recipients]**beneficiaries** (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive [and behavioral] impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases which require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

…

"Ombudsman" means the Office of the Ombudsman for the Institutionalized Elderly.

…

"Pre-admission screening (PAS)" means that process by which all Medicaid eligible [recipients] **beneficiaries** seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by [the Regional Staff Nurse] **professional staff designated by the Department** to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D-17.10. (P.L.1988, c. 97).

…

"Prior authorization" means approval granted by the [Division of Medical Assistance and Health Services] **Department** through the appropriate [Medicaid District Office (MDO)] **Long-Term Care Field Office (LTCFO)** for payment for NF [or before other Medicaid covered] services [are] rendered to a Medicaid [recipient] **beneficiary**, in accordance with this chapter.

"Professional staff designated by the Department" means a registered nurse or professional social worker who performs health needs assessments and counseling on alternative options and care management as required by this chapter. Professional social workers employed by the State or a political subdivision thereof are not required to be licensed or certified.

["Regional staff nurse (RSN)" means a registered professional nurse employed by the Division of Medical Assistance and Health Services who performs health needs assessments as required by this chapter.]

…

"Resident" means a Medicaid eligible or potentially eligible [recipient] **beneficiary** residing in an NF.

…

["Section Q " means the resident classification portion of the standardized resident assessment (SRA) instrument which identifies an individual NF resident's nursing service requirements based on the standards at N.J.A.C. 10:63-2.2(a).]

…

"Social services" means those services provided to meet the emotional and social needs of the Medicaid [recipient] **beneficiary** and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

"Special care nursing facility (SCNF)" means a NF or separate and distinct unit within a Medicaid certified conventional NF which has been approved by the [Division of Medical Assistance and Health Services] **Department** to provide care to New Jersey Medicaid [recipients] **beneficiaries** who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. [10:63] **8:85**-2, Nursing Facility Services.

…

"Track of care" means the designation of the setting and scope of Medicaid services determined by the PAS process conducted by the [RSN] **professional staff**

designated by the Department following assessment of the Medicaid eligible or potentially eligible Medicaid [recipient] **beneficiary**, as follows:

1.- 3. (No change.)

…

[10:63]**8:85**-1.3 Program participation

(a) A NF shall comply with the following requirements in order to be eligible to participate in the New Jersey Medicaid program. An in-State NF shall:

1. (No change.)

2. Be certified by the New Jersey Department of Health and Senior Services, and in the case of both Medicare and Medicaid, by the [Health Care Financing Administration (HCFA)] **Centers for Medicare & Medicaid Services (CMS)**, which assures that the NF meets the [federal] **Federal** requirements for participation in Medicaid and Medicare;

3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application [FD-20] **PE-1 that establishes eligibility to receive direct payment for services to recipients under the New Jersey Medicaid program** (see Appendix A[, incorporated herein by reference] **and as posted at www.state.nj.us/health/ltc/formspub.htm**), the signing of a [Provider] **Participation** Agreement [MCNH-38] **PE-3, which is the participation**

agreement between the nursing facility and DHSS which stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85 (see Appendix B[, incorporated herein by reference] **and as posted at www.state.nj.us/health/ltc/formspub.htm**), and submittal of the [HCFA]**CMS**-1513, Ownership and Control Interest Disclosure Statement **that is required to be completed before the State agency or Federal agency will enter into a contract for reimbursement of medical services** (see Appendix C[, incorporated herein by reference] **and as posted at www.state.nj.us/health/ltc/formspub.htm**). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. [10:63]**8:85.** Continued participation as a New Jersey Medicaid provider will be subject to recertification by the [New Jersey] Department [of Health] and compliance with all Federal and State laws, rules and regulations. Upon recertification by the Department [of Health], each NF will receive notification from the **Department's Office of** Provider Enrollment [Unit, Division of Medical Assistance and Health Services], informing the facility that their provider agreement is being continued.

4. File a completed Cost [Study] **Report** for **Nursing** Facility form **Version 5.0, an annual report which must be filed every NF seeking Medicaid payment that establishes a per diem rate based upon information provided by the NF** (see Appendix D**)**]], incorporated herein by reference)] with the [New Jersey State] Department [of Health and the Division of Medical Assistance and Health

Services]. After the initial cost [study] **report** is filed, the provider shall file a Cost [Study] **Report** for **Nursing** Facility form **Version 5.0** annually.

5. (No change.)

6. Accept as payment in full [for covered services, the amounts paid in accordance with Medicaid policy defined at N.J.A.C. 10:49-9.3(a)2] **the Medicaid program's reimbursement for all covered services delivered during that period when, by mutual agreement between Medicaid and the facility, the beneficiary is under the provider's care, in accordance with 42 CFR §447.15 and N.J.S.A. 30:4D-6(c)**; and

7. (No change.)

[10:63]**8:85**-1.4 (No change in text.)

[10:63]**8:85-**1.5 [Occupancy] **Medicaid occupancy** level

(a) The NF Medicaid occupancy level shall be calculated by adding the total days for Medicaid [and public assistance recipients] **beneficiaries** residing in the NF during the month, dividing this sum by the number of days in the month to determine the average daily census, and dividing this amount by the total number of licensed long-term beds.

1. – 3. (No change.)

[10:63]**8:85**-1.6 Termination of a **Medicaid** NF provider agreement

(a) The [Division] **Department** shall terminate a NF's **Medicaid** provider agreement if [the Division]:

1. [Receives notice from the New Jersey State Department of Health] **The Long Term Care Licensing and Certification Program of the Department** or [HCFA] **the Centers for Medicare & Medicaid Services (CMS) determines** that the NF is no longer certified to provide NF services. In that case:

i. The **Medicaid** provider agreement shall be terminated 23 days from the survey date if the [New Jersey State Department of Health or the Secretary of the Department of Health and Human Services] **Long Term Care Licensing and Certification Program of the Department or the CMS** [find] **finds** that deficiencies pose immediate jeopardy to residents' health and safety.

ii. If the deficiencies do not pose immediate jeopardy to the resident's health and safety, the **Medicaid** provider agreement shall be terminated ninety days from the survey date.

iii. The termination of provider agreement shall be rescinded if, prior to the effective date of termination, the [Division is notified by the New Jersey

Department of Health or the Secretary of the Department of Health and Human Services] **Long Term Care Licensing and Certification Program of the Department or the CMS determines** that the deficiencies have been satisfactorily corrected and the NF is certified to provide NF services; and

2. [Determines] **The Department determines** that other good cause for such termination exists as cited at N.J.A.C. 10:49-11**.1** or as a result of a pattern of aberrancies reported in a clinical audit as defined at N.J.A.C. [10:63]**8:85**-1.12.

[10:63]**8:85-**1.7 Administrative appeal of denial, termination or non-renewal of NF certification or Medicaid Provider Agreement

(a) Any NF whose certification or Medicaid Provider Agreement is denied, terminated or not renewed shall have the opportunity to request a full evidentiary hearing before an administrative law judge, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A- 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

1. In order to obtain a hearing, the NF shall submit, within 20 days from the date of the [Division] letter proposing termination, a written request to the [Chief, Office of Legal and Regulatory Liaison, Division of Medical Assistance and Health Services, Mail Code # 3, CN 712, Trenton, New Jersey 08625-0712]

Division of Long Term Care Systems, Office of Program Compliance, PO Box 367, Trenton, New Jersey 08625-0367.

2. - 4. (No change.)

i. - iii. (No change.)

(b) A (S)NF whose certification or Medicare/Medicaid provider agreement is denied, terminated or not renewed by [HCFA]**CMS**, may request a hearing pursuant to 42 CFR 498.40 by submitting a written request to the [Health Care Financing Administration] **Centers for Medicare & Medicaid Services**, Division of Health Standards and Quality, Attn: Coordinator Hearing and Appeals, Federal Building Room 3821, 26 Federal Plaza, New York, New York 10278.

1. (No change.)

[10:63-1.8 Admission, transfer and readmission; general

(a) – (b) (No change.)

(c) A Medicaid eligible individual identified as MI residing in a Medicaid participating NF, who is admitted to a psychiatric unit for treatment, shall not be subject to PASARR requirements, prior to returning to the NF. However, if the resident's condition indicates

a significant change in mental or behavioral status, the NF shall immediately secure an Annual Resident Review (ARR) as defined in N.J.A.C. 10:63-1.11(e).

(d) In cases of transfer of a NF resident with MI or MR to a hospital or another NF, the admitting NF is responsible for ensuring that copies of the resident's most recent PASARR resident assessment reports, SRA and current HSDP accompany the transferring resident.

(e) Payment will not be made by the New Jersey Medicaid program for NF services provided to private paying patients who have applied for Medicaid benefits unless they have been authorized to receive NF services by the MDO. (See N.J.A.C. 10:63-1.11).

(f) The NF shall obtain a statement of the Medicaid recipient's budgetary information on the PA-3L Statement of Available Income for Medicaid Payment (see Appendix F, incorporated herein by reference) from the appropriate CWA.

(g) Notification of the approval or denial of NF services by the MDO shall be provided to the applicant and other individuals and agencies, as required in N.J.A.C. 10:49-10.4.

(h) In the event that a NF admits a Medicaid eligible recipient or an individual who may become Medicaid eligible within 180 days of admission without preadmission screening by the MDO, the effective date of the initial authorization will be the date of the MDO assessment. Facilities admitting such individuals without preadmission screening shall

not be reimbursed by the New Jersey Medicaid program for any care rendered before the MDO assessment.

(i) When an inpatient is to be discharged from the hospital to a NF, the transfer shall, to the extent possible, be to a Medicare/Medicaid participating (S)NF when Medicare (Title XVIII) benefits are available.

(j) When an inpatient is discharged from the hospital to a Medicaid certified NF, the NF shall be responsible for securing a legible abstract or summary prepared by either the attending physician or the hospital and signed by attending physician, covering the Medicaid recipient's care in the hospital. This information shall be forwarded to the NF along with the HSDP and MDO authorization and where applicable, PASARR-related material.

(k) The NF shall submit a Notification From Long-Term Care Facility of the Admission or Termination of a Medical Patient MCNH 33, (see Appendix G, incorporated herein by reference) along with a copy of the hospital transfer form or its equivalent PA-4 Form, Certification of Need for Patient Care in Facility other than Public or Private General Hospital (see Appendix H, incorporated herein by reference) to the MDO serving the county where the NF is located, within two working days of admission.

(l) When a resident is transferred to a hospital, there is no change in the policy for readmission to the NF or the termination from the NF. The MCHN 33form shall be

completed, dated and signed for each readmission and termination of a Medicaid recipient. The MCHN 33form shall reflect the room number and bed number to which or from which the Medicaid patient has been transferred or readmitted.]

8:85-1.8 Pre-Admission Screening (PAS), admission, and authorization

(a) Pursuant to N.J.S.A. 30:4D-17.10, a Medicaid participating NF shall not admit any individual who is Medicaid eligible or who may become Medicaid eligible within 180 days of admission to the facility, or an individual with mental illness (MI) or mental retardation (MR) who meets the Pre-Admission Screening and Resident Review (PASARR) Criteria as defined at 42 CFR § 483.102 as amended and supplemented regardless of payment source, unless that individual has been prescreened by professional staff designated by the Department and determined appropriate for NF placement.

1. A Medicaid eligible individual residing in a Medicaid participating NF who is transferred to an acute care hospital shall not require preadmission screening prior to returning to the same or another NF.

2. A Medicaid eligible individual identified as having MI residing in a Medicaid participating NF who is admitted to a psychiatric unit for

treatment shall not be subject to PASARR requirements prior to returning to the NF.

3. In cases of transfer of a NF resident with MI or MR to another NF, the admitting NF shall be responsible for ensuring that copies of the resident's most recent PASARR resident assessment reports, SRA and current HSDP accompany the transferring resident.

(b) Payment will not be made by the New Jersey Medicaid program for NF services provided to private paying residents who have applied for Medicaid benefits unless they have been authorized to receive NF services through preadmission screening.

1. In the event that a NF admits a Medicaid eligible beneficiary or an individual who may become Medicaid eligible within 180 days of admission without preadmission screening, the effective date of the initial authorization will be the date of the assessment. Facilities admitting such individuals without preadmission screening shall not be reimbursed by the New Jersey Medicaid program for any care rendered before the assessment.

(c) Upon admission of a Medicaid eligible beneficiary, the NF shall submit a Notification From Long-Term Care Facility of the Admission or Termination of a

Medicaid Patient, LTC-2 Form in which a facility submits notification to the Long Term Care Field Office of an admission or discharge of a Medicaid eligible beneficiary (posted at www.state.nj.us/health/ltc/formspub.htm or see Appendix E), to the Long Term Care Field Office (LTCFO) serving the county where the NF is located, within two working days of admission.

1. The NF shall obtain a statement of the Medicaid beneficiary's budgetary information on the PA-3L Statement of Income Available for Medicaid Payment (as posted at www.state.nj.us/health/ltc/formspub.htm or see Appendix F) from the appropriate CWA.

(d) Professional staff designated by the Department will review the medical, nursing, and social information obtained at the time of assessment, as well as any other supporting data, in order to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The professional staff designated by the Department will authorize or deny NF placement based on the service requirements of N.J.A.C. 8:85-2 and the feasibility of alternative placement and will designate the track of care.

1. If alternative care is available, accessible, and appropriate to the needs of the individual, the request for NF placement will be denied.

i. If an appropriate alternative plan of care becomes available and accessible for a person already approved for NF care and awaiting placement, the authorization for NF placement will be rescinded.

2. For each NF applicant with MI or MR who is determined to require NF placement, the State mental health or mental retardation authority, as appropriate, will determine whether the individual requires specialized services for MI or MR, prior to issuance of the approval for NF placement.

i. For the MI diagnosed individual, the professional staff designated by the Department shall request that the Psychiatric Evaluation form that helps determine the need for specialized services for MI or MR patients and includes personal identification, clinical evaluation notes, diagnoses, lists of medications and referral information (as posted at www.state.nj.us/health/ltc/formspub.htm) or see Appendix G, incorporated by reference , provided by the mental health authority, be completed and forwarded to the Division of Mental Health Services for determination of need for specialized services. The evaluation shall be completed by a psychiatrist, physician (doctors of medicine or osteopathy) certified nurse practitioner (CNP) or a clinical nurse specialist (CNS). CNPs and CNSs must be certified in the advance practice of psychiatric/mental health. For individuals with a change of condition as defined by the MDS, a

psychiatric consultant to the NF should complete the psychiatric evaluation form.

(1) Individuals having a primary diagnosis of dementia including Alzheimer's disease are not subject to the State MI determination for specialized services prior to admission to the NF.

ii. For the MR diagnosed individual, the LTCFO will contact the appropriate DHS, Division of Developmental Disabilities (DDD) staff to complete the determination for specialized services. In the case of an individual dually diagnosed with MI and MR, the determination by the mental health authority will be completed first.

(1) Individuals with MR and a diagnosis of dementia including Alzheimer's disease are subject to the State MR determination for specialized services prior to admission to the NF.

iii. The results of the MI or MR determinations will be forwarded to the LTCFO and will be conveyed to the referring individual. If no specialized services are required, the NF approval letter will accompany the MI/MR agency report.

iv. In the event the individual is determined by the State MI or MR authority to require specialized services, NF placement is inappropriate. The MI or MR authority will assist in finding appropriate placement/services for the individual.

v. If NF placement is denied based on failure to meet the NF requirements of N.J.A.C. 8:85-2, further screening by the State MI or MR authority is not required.

(e) As part of the PAS determination, the track of care will be designated based on the following criteria:

1. Track I designates long-term NF care and shall be assigned in situations in which long-term placement is required because clinical prognosis is poor, and in which, during the assessment process, it is determined that short-term stays are neither realistic nor predictable. Individuals designated for Track I services shall, at a minimum, require nursing services as required by N.J.A.C. 8:85-2.

i. A Track I designation shall not preclude the possibility of future discharge. The professional staff designated by the Department will monitor those individuals with discharge potential, reassess the

individual, and update the Health Services Delivery Plan (HSDP) for a track change if appropriate.

2. Track II designates short-term NF care and shall be assigned in those situations in which comprehensive and coordinated NF services are required to stabilize medical conditions, promote rehabilitation, or restore maximum functioning levels and to provide a therapeutic setting which assures family counseling and teaching in preparation for discharge to the community setting.

i. Individuals designated for Track II shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly in cases in which the individual is motivated towards NF alternatives and/or in which caregivers, through case management intervention, may obtain services that make return to the community a viable option.

3. Track III designates long-term care services in the community and shall be assigned in the case of individuals who meet the requirements of N.J.A.C. 8:85-2, but can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services Waiver Programs.

(f) The following procedure is to be used by the referent when seeking authorization through PAS prior to the admission of Medicaid eligible individuals or for private pay individuals who may become eligible for Medicaid within six months.

1. The referent shall be responsible for identifying a potentially Medicaid eligible individual, a Medicaid eligible individual, or an individual subject to PASARR requirements who may be at risk for NF placement pursuant to the "At-Risk Criteria for Nursing Facility Placement" (as posted at www.state.nj.us/health/ltc/formspub.htm) or (see Apendix H, incorporated herein by reference). These individuals shall be referred to the LTCFO for a PAS assessment and, if appropriate, to the CWA for eligibility determination.

i. The professional staff designated by the Department will conduct a PAS assessment utilizing a standardized assessment instrument and shall verbally advise the referent and family/authorized representative of the assessment decision and, if appropriate, shall advise that an evaluation for PAS MI/MR specialized services is required. The Health Service Delivery Plan (HSDP) (posted at www.state.nj.us/health/ltc/formspub.htm), which identifies the individual's current and potential health problems and care needs,

and signed approval/denial letter, as appropriate, shall be given to the referent. The original letter shall be sent by the LTCFO to the individual/family with copies to the CWA. For PAS MI/MR individuals, a signed approval letter and HSDP will only be forwarded to the individual/family, with a copy to the referent, after the determination has been made that no specialized services are required.

(1) If an individual being transferred from a hospital setting to a NF is or will be eligible for Medicare benefits, the transfer shall, to the extent possible, be made to a Medicare/Medicaid participating (S)NF.

2. The referent shall be responsible for identifying individuals who are currently residing in a Medicaid participating NF who may become eligible for Medicaid within six months. These individuals shall be referred via the LTC-2 form to the LTCFO for a PAS assessment with a copy of the form sent to the CWA for eligibility determination.

i. The NF shall refer such individuals to the LTCFO for a PAS evaluation no later than six months prior to the anticipated date of Medicaid eligibility.

ii. The CWA will forward the LTC-2 Form (Notification from Long-Term Care Facility of Admission or Termination of Medicaid Patient) to the LTCFO indicating a change in the individual's status from private pay to Medicaid status.

3. Individuals residing in the community who are Medicaid-eligible beneficiaries or who may become eligible for Medicaid within six months of admission, or individuals subject to PASARR requirements as defined at 42 CFR 483.102, shall be referred to the LTCFO for preadmission screening and, if appropriate, to the CWA for eligibility determination, when seeking admission to a Medicaid participating NF.

i. Upon receipt by the LTCFO of a PA-4 Form (Certification of Need for Patient Care in Facility Other than Public or Private General Hospital) or physician statement which substantiates diagnosis and describes the individual's care needs, a PAS assessment will be conducted. The individual will receive notification from the LTCFO, in writing, of approval or denial of NF services. Copies of the letter will be sent to the CWA.

ii. For individuals residing in the community who meet the PASARR/MI criteria, a Psychiatric Evaluation form must be completed and forwarded to the Division of Mental Health Services

or determination of need for specialized services. The evaluation shall be completed by a psychiatrist, physician (doctors of medicine or osteopathy) certified nurse practitioner (CNP) or a clinical nurse specialist (CNS). CNPs and CNSs must be certified in the advance practice of psychiatric/mental health (N.J.S.A. 45:11-45 et seq.).

iii. For individuals residing in the community who meet the PASARR/MR criteria, DHS, Division of Developmental Disabilities (DDD) staff shall complete the evaluation for specialized services. In the case of an individual dually diagnosed with MI and MR, the determination by the mental health authority will be completed first.

(g) Authorization of out-of-State placement shall include the following additional conditions:

1. Prior authorization shall be obtained from the Department for out-of-state NF services and shall be considered only when a required long-term care service is not available in New Jersey.

2. The out-of-State facility shall be licensed as a NF or SCNF by that state, and the rate of reimbursement shall not exceed that authorized by the Title XIX program in the state in which the facility is located, or the

reimbursement rate authorized by the New Jersey Health Services Program (Medicaid), whichever is lower.

3. Requests for prior authorization for out-of-State placement shall be accompanied by sufficient evidence of medical necessity to substantiate the request. The Department will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the beneficiary in a NF in New Jersey. The request must be submitted to:

Department of Health and Senior Services

Office of Long Term Care Options

P.O. Box 807

Trenton, New Jersey 08625-0807

4. Prior to submitting a request for out-of-State placement, the beneficiary shall comply with the requirements of the pre-admission screening process as specified in this subchapter.

(h) The procedure for NF continued stay/alternate care shall be as follows:

1. The professional staff designated by the Department shall periodically assess Medicaid beneficiaries, review the NF's assessments, patient

classifications, and case mix reporting, and may recommend alternatives to NF stay or deny continued stay.

2. Professional staff designated by the Department shall, on an ongoing basis, provide care management to Medicaid beneficiaries following placement to monitor the provision of NF care in order to:

i. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;

ii. Assure the delivery of timely and coordinated services;

iii. Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are coordinated, effective, and cost prudent; and

iv. Facilitate discharge planning and promote appropriate placement to alternate care settings.

3. The professional staff designated by the Department shall examine resident records for proof of continued vigilance and effort by the facility to utilize alternative means of care for all residents.

i. Beneficiaries designated as track II (short-term) shall be monitored closely by the Department to assure active participation by the facility in the discharge planning process.

(i) If a NF resident who meets PASARR criteria as defined in 42 CFR § 483.102 as amended and supplemented and incorporated herein by reference for MI/MR shows a significant change in condition as defined by the MDS, the NF shall initiate treatment to meet immediate needs. A comprehensive reassessment shall be completed by the end of the 14th day of the documented change in condition, noting that a significant change has occurred. Within seven days of completing the reassessment, the facility shall revise the care plan based on that reassessment. The NF shall make a clinical judgement, based on the clinical data, as to whether or not a PASARR review by the Division of Mental Health Services or DDD is needed.

(j) Medicaid beneficiaries residing in a NF approved for a SCNF rate of reimbursement who continue to require long-term supportive and restorative nursing services and therapeutic treatment for continued maintenance, in the absence of significant clinical change or complex service needs, shall be approved for conventional NF placement (adult or pediatric) by the Department after consideration and rejection of all possible means of alternate care.

(k) The NF shall notify the LTCFO, via the LTC-2 Form, of the termination of nursing facility services due to the death of a resident, either in the NF or while hospitalized; discharge to home or other community living arrangement; transfer to another NF; or ineligibility determination.

[10:63]**8:85**-1.9 Waiting list

(a) The NF shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the NF are to be added to the top of the list as soon as the hospital notifies the NF of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions **or transfers from another nursing facility**.

1. (No change.)

2. It shall be unlawful discrimination for any Medicaid participating NF whose Medicaid occupancy level is less than the Statewide occupancy level to deny admission to a Medicaid eligible individual who has been authorized for NF services by the [MDO] **LTCFO** when a NF bed becomes available in accord with the waiting list.

i. (No change.)

[10:63]**8:85**-1.10 Involuntary transfer [initiated by the facility]

(a) The [Division] **Department** recognizes that there may be problems in relocating infirm aged persons from a NF. The purpose of this rule is to specify the circumstances in which the involuntary transfer of a Medicaid [recipient] **beneficiary** in a NF is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid [recipient] **beneficiary** from a NF.

(b) (No change.)

(c) This rule shall apply to the involuntary transfer of a Medicaid [recipient] **beneficiary** at the request of a NF. This rule shall not apply to the [Division's] **Department's** utilization review process, nor to the movement of a Medicaid [recipient] **beneficiary** to another bed within the same facility.

(d) A transfer of a Medicaid [recipient] **beneficiary** which was not consented to or requested by the [recipient] **beneficiary** or by the [recipient's] **beneficiary's** family or authorized representative shall be considered an involuntary transfer. A Medicaid [recipient] **beneficiary** is a Medicaid eligible individual residing in a NF which has a Medicaid provider agreement. This includes Medicaid [recipients] **beneficiaries** over the minimum number stipulated in the agreement or an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

(e) A Medicaid [recipient] **beneficiary** shall only be involuntarily transferred when adequate alternative placement, acceptable to the [Division] **Department**, is available. A Medicaid [recipient] **beneficiary** may be transferred involuntarily only for the following reasons:

1. (No change.)

2. The transfer is necessary to protect the physical welfare or safety of the [recipient] **beneficiary** or other residents;

3. (No change.)

4. The transfer is required by the New Jersey State Department of Health **and Senior Services** pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider [by the Division].

(f) In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled. Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The effect of relocation trauma on the [recipient] **beneficiary**;

2. The proximity of the proposed placement to the present facility and to the family and friends of the [recipient] **beneficiary** ; and

3. (No change.)

(g) The procedure for involuntary transfer shall be as follows:

1. The NF shall submit to the [Division] **LTCFO** a written notice with documentation of its intention [to] and reason for the involuntary transfer of a Medicaid [recipient] **beneficiary** from the facility;

2. If the [MDO] **LTCFO** determines that an involuntary transfer is appropriate, the [recipient] **beneficiary** and/or the [recipient's] **beneficiary's** authorized representative shall be given 30 days prior written notice by the [Division] **NF** that a transfer is proposed by the NF and that such transfer will take effect upon completion of the relocation program specified in (h) **below**. **Additionally the NF shall forward a copy of the written notice to the LTCFO and Ombudsman.** The written notice to the [recipient] **beneficiary** and/or authorized representative [will] **shall** advise of the right to a hearing **and shall include the address where to send the request for a hearing.** If the [recipient] **beneficiary** requests a hearing within 30 days of the date of the written notice, the transfer is stayed pending the decision following the hearing. In those instances where the

[Division] **LTCFO** determines that an acute situation or emergency exists, the transfer shall take [effect] **place immediately. The beneficiary and/or the beneficiary's authorized representative shall be given 30 days after transfer to request a hearing**;

3. [The Division] **DMAHS** will comply with the hearing time requirements in State and Federal rules and regulations, unless an adjournment is requested by the appellant;

4. The hearing shall be conducted at a time and place convenient to the [recipient] **beneficiary**. Notification shall be sent to all parties concerned;

5. All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the [Division] **DMAHS**.

(h) The relocation procedure shall be as follows:

1. In the event the relocation of a [recipient] **beneficiary** is the final [Division] **Department** determination, the [Division] **Department** shall afford relocation counseling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.

2. The staff of the transferring and receiving NFs shall [assist in] **carry out** the transfer process, although responsibility and authority for the coordination and transfer rests with the [Division] **Department** and will include:

i. Evaluation and review by appropriate [MDO] **LTCFO** staff;

ii. Initial [recipient] **beneficiary**, family or authorized representative counseling;

iii. Involvement of the [recipient] **beneficiary**, family or authorized representative in the placement process with recognition of their choices;

iv. [Recipient] **Beneficiary** preparation and site visit for all able to do so within the capability of the transferring agent;

v. Accompaniment on the transfer day by a family member, authorized representative or attendant, unless the [recipient] **beneficiary** otherwise requests;

vi. - vii (No change.)

(i) No owner, administrator or employee of a NF shall attempt to have [recipients] **beneficiaries** seek relocation by harassment or threats. Such action by or on behalf of

the NF may be cause for the curtailment of future admission of Medicaid [recipients] **beneficiaries** to the NF or for termination of the Medicaid Provider Agreement with the NF, depending upon the nature of the action.

(j) Any complaints regarding the handling of [recipients] **beneficiaries** relative to their transfer shall be referred to the [Division] **Department** for investigation and corrective action.

8:85-1.11 (Reserved)

[10:63]**8:85**-1.12 Clinical audit

(a) (No change.)

(b) Professional staff **designated by the Department** [from the Medicaid District Office (MDO)] shall periodically conduct a post payment review of New Jersey Medicaid [recipients] **beneficiaries** for whom NF services have been provided. The review shall principally involve assessment of the Medicaid [recipient's] **beneficiary's** care needs and evaluation of treatment outcomes, based on direct observation of the [recipient] **beneficiary** and examination of clinical and related records. The focus of the review shall be on the following areas:

1. Comparative analysis of [NF claim reporting to recipient's] **a beneficiary's** identified care needs **to NF claim reports**;

2.- 3. (No change.)

(c) Enforcement action will be taken by the [Division] **Department** as follows:

1.- 2. (No change.)

[10:63]**8:85**-1.13 Clinical and related records

(a) An individual clinical record shall be maintained for each Medicaid [recipient] **beneficiary** covering his or her medical, nursing, social and related care in accordance with accepted professional standards and licensing standards as set forth by the Department**'s** [of Health] Long Term Care Facilities Licensing Standards, N.J.A.C. 8:39. All entries on the clinical record shall be current, dated and signed by the appropriate staff member [and]**. The clinical record, HSDP approval letter and if appropriate, the PASARR evaluation shall be** readily available at the appropriate nurses' station for review by [DMAHS] **DHSS** staff.

(b) - (f) (No change.)

(g) Billing and financial records rules are as follows:

1. The Fiscal Agent Billing Supplement identifies the procedures required for the general use of the billing transaction forms and computer generated forms. All appropriate reports shall be retained until audited by the [Division] **Department**.

2. The facility shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of Medicaid [recipient] **beneficiary** funds, which shall be subject to review and fiscal audit by the State of New Jersey as may be required. A [recipient] **beneficiary** shall be credited with the maximum amount of personal needs allowance funds authorized by Federal or State law for each month that such records or accounts are unavailable.

3. Any and all financial and other records relating to [recipient's] **beneficiary's** personal needs allowance accounts, income, cost [studies] **reports**, and billings to the Medicaid program shall be maintained and retained in accordance with professional standards and practices for the longest of the following periods of time:

i.- iii. (No change.)

4. (No change.)

5. Claims for NF services that are older than 12 months will be rejected.

i. (No change.)

ii. For purposes of this time limitation, a claim is the submission of a TAD, provided by the fiscal agent for the New Jersey Medicaid program, indicating a request for reimbursement for authorized NF services provided to an eligible [recipient] **beneficiary** and which has been returned to the fiscal agent within the time limit specified. An adjustment form (FD999) or an [MCNH-33] **LTC-2** shall not constitute a claim for payment;

iii. (No change.)

[10:63]**8:85**-1.14 Absence from facility due to hospital admission or therapeutic leave; bed reserve

(a) The bed reserve policy for hospital admissions is as follows:

1. The NF shall reserve and hold the same room and the same bed of the Medicaid [recipient] **beneficiary** transferred to a general or psychiatric hospital for a period not to exceed 10 days. The NF shall determine the individual's status or whereabouts during or after the 10-day bed reserve period.

i. If the resident is not readmitted to the same room or the same bed or the same NF during a bed reserve period, the NF requesting bed reserve

reimbursement shall record on the resident's chart and make available for [Division] **Department** review, a justification for the action taken. Pending outcome of the [Division's] **Department's** review, the facility may be subject to forfeiture of bed reserve reimbursement.

ii. Said reserved bed shall remain empty and shall not be occupied by another individual during the bed reserve period**, unless authorized by the Department.**

2. [Effective July 1, 1996, reimbursement] **Reimbursement,** not to exceed 10 days, shall be at 90 percent of the rate the NF received prior to the transfer to the hospital.

i. The [recipient's] **beneficiary's** available monthly income shall be applied against the per diem cost of care.

ii. Medicaid reimbursement for bed reserve will not be made to a NF when the NF per diem payment for a "Medicaid eligible beneficiary" is being made by a third party insurer.

iii. When a Medicaid beneficiary is transferred back to the NF and then readmitted to a general or psychiatric hospital, the NF will not be reimbursed for an additional 10 day bed reserve if the Medicaid

beneficiary was not in the NF for at least 24 hours prior to being readmitted to the hospital.

3. If readmission to the NF does not occur until after the 10 day bed reserve period, the next available bed shall be given to the Medicaid [recipient] **beneficiary**. The [recipient's] **beneficiary's** name shall be placed on the chronological listing of persons waiting admission/ readmission to the NF, and the [recipient] **beneficiary** waiting for readmission shall have priority for the next available bed in the facility.

4. The bed reserve policy applies to any person in the NF eligible to receive Medicaid benefits; for example, a Medicare/Medicaid [recipient] **beneficiary** who, at the time of transfer to the hospital, might be eligible for long-term care services under Medicare benefits.

5. Admission procedures (see N.J.A.C. [10:63]**8:85**-1.8) shall be followed when the Medicaid [recipient] **beneficiary** has been readmitted following a period of hospitalization.

(b) Requirements concerning absence due to therapeutic leave are as follows:

1. The **New Jersey** Medicaid program will reimburse NFs their per diem rate for reserving beds for Medicaid [recipients] **beneficiaries** who are absent from the

facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of unused leave days may be carried over into the next calendar year. The facility shall maintain accurate leave day records on the Medicaid [recipient's] **beneficiary's** chart, for review by the [Division] **Department**.

2. (No change.)

3. The absence of a Medicaid [recipient] **beneficiary** from the facility for the purpose of therapeutic leave shall be authorized in writing by the [recipient's] **beneficiary's** attending physician and shall be included in the [recipient's] **beneficiary's** plan of care.

4. In those instances where a [recipient] **beneficiary** is in more than one NF within a calendar year, the receiving facility shall determine the number of therapeutic leave days that have been allowed for payment by the sending facility within the same calendar year. A record of any leave days shall be a part of the information provided on the Patient Information Transfer Form.

5. The facility shall reserve and hold the same room and bed for the Medicaid [recipient] **beneficiary** on a therapeutic home visit. Said bed shall not be

occupied by another individual during the period of time in which the Medicaid [recipient] **beneficiary** is on such leave.

6. Where a [recipient's] **beneficiary's** condition or situation requires more than 24 therapeutic leave days annually, as determined by the [recipient's] **beneficiary's** attending physician, prior authorization for the additional days shall be obtained from the [MDO] **LTCFO**. The request for prior authorization shall be submitted in writing to the [MDO Director] **LTCFO Field Office Manager,** over the signature of the attending physician. A facility shall be reimbursed its per diem rate for reserving a bed for a Medicaid [recipient] **beneficiary** for any additional days so authorized.

[10:63]**8:85**-1.15 Complaints

(a) The [Division] **Department** will receive, document and investigate complaints from multiple sources and take appropriate corrective action as required. It is the [Division's] **Department's** policy that the source of the complaint be held confidential, unless disclosure permission is obtained from the complainant.

(b) In addition to investigation by the [Division] **Department**, when complaints against a facility indicate the facility's failure to correct previously reported survey deficiencies or to comply with established licensure and Medicare/Medicaid certification standards, such complaint reports will be forwarded to the [New Jersey State Department of Health and the] Office of the Ombudsman for the Institutionalized Elderly for review and action.

Any complaints or reports received by the [Division] **Department** indicating legal violations will be referred to the office of the Attorney General for review and action, as required.

[10:63]**8:85**-1.16 Utilization of resident's income for cost of care in the NF and for PNA

(a) After provision for the resident's Personal Needs Allowance (PNA) is met, and then after provision for other allocations such as maintenance of spouse and/or dependent's home are satisfied, the remainder of the Medicaid [recipient's] **beneficiary's** income shall be applied to the cost of care in the NF, which includes per diem, bed reserve and other allowable expenses.

1. The amount of income which shall be collected by the NF from the [recipient] **beneficiary**, [recipient's] **beneficiary's** family or Representative Payee (if any) will be established in the process of determining eligibility and identified by form PA-3L, Statement of Income Available for Medicaid Payment, issued by the CWA. The NF shall collect all of the recipient's income to offset the Medicaid payment.

2. (No change.)

3. The New Jersey Medicaid program encourages families or any other concerned individual(s) to make voluntary monetary contributions to the State of

New Jersey on behalf of Medicaid [recipients] **beneficiaries residing in nursing facilities**. Inquiries should be directed to the [Division of Medical Assistance and Health Services, Bureau of Administrative Control, Mail Code # 6, CN-712, Trenton, New Jersey 08625-0712] **Division of Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722**.

(b) For all institutionalized aged, blind, and disabled individuals who are eligible for Medicaid, a designated amount of income as determined by State law (N.J.S.A. 30:4D-6a) shall be protected for personal needs allowance.

1. Certain individuals in a NF have no income, or insufficient income to provide a maximum amount of PNA. For those individuals not already deemed eligible for SSI, the facility shall insure that the application for SSI benefits has been made. PA-3L's for those [recipients] **beneficiaries** who only receive an SSI check can be obtained from the [Bureau of Claims and Accounts, CN 712, Trenton, New Jersey 08625-0712] **Division of Senior Benefits and Utilization Management, Office of Provider Relations, PO Box 722, Trenton, New Jersey 08625-0722**.

2. Once the NF initiates billing for a Medicaid beneficiary, that Medicaid beneficiary shall be considered a Medicaid beneficiary for the full term of stay in the NF (that is, until death or physician discharge) unless the patient loses eligibility during the stay or the beneficiary or authorized

representative submits to the LTCFO, prior to death or discharge, a notarized statement to terminate benefits.

i. After a beneficiary dies or is discharged, under no circumstances shall that beneficiary's Medicaid billing status be terminated prior to the date of death or discharge for the purpose of avoiding utilization of available income against cost share.

(c) Each Medicaid [recipient] **beneficiary** residing in a NF shall be permitted to accumulate a sum of money from the PNA which, when combined with other resources retained by or for the person, does not exceed the maximum resource standard in **the Department of Human Services Medicaid Only Manual at** N.J.A.C. 10:71-4.5.

1. If the NF is handling the PNA, the facility shall closely monitor the PNA account and inform the [recipient] **beneficiary** and/or his or her representative when the amount comes within $200.00 of the resource eligibility cap. If the PNA is in excess of the resource standard defined in N.J.A.C. 10:71-4.5, the [recipient] **beneficiary** and/or his or her representative shall be advised of his or her right to reduce the excess monies and that the [recipient] **beneficiary** may be terminated from Medicaid coverage, unless the amount in excess of the resource standard is expended.

2. The [recipient] **beneficiary** may choose to reduce excess PNA by applying some of the accumulated PNA toward past expenditures paid for his or her care by the Medicaid program. Checks payable to the "Treasurer, State of New Jersey", may be directed to the [Chief, Bureau of Administrative Control, Division of Medical Assistance and Health Services, Mail Code # 6, CN-712, Trenton, NJ 08625-0712] **Division of Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722**.

(d) (No change.)

(e) The personal needs allowance (PNA) shall be used as follows:

1. The PNA is intended to meet the personal and incidental needs of a [recipient] **beneficiary** residing in a NF, in keeping with his or her wishes. The PNA is not intended to be applied against outstanding balances for the cost of care.

2. The NF shall not charge for items the [recipient] **beneficiary** has not requested, nor for any items about which the [recipient] **beneficiary** has not been informed in advance that he or she will be billed.

3. NFs shall not charge for any item or service reimbursable under the Medicaid program. A facility may charge the difference between the cost of the brand a

[recipient] **beneficiary** requests and the cost of the brand generally provided by the facility, if the facility chooses to provide the requested brand. NFs shall not require the purchase of non-covered items as a condition for admission.

4. The basic items that NFs shall make available for [recipient] **beneficiary** use under the Medicaid program include:

i.- iv. (No change.)

5.-6. (No change.)

7. The PNA may be used to continue a bed reserve, if a [recipient] **beneficiary** transferred to a hospital is unable to return within the 10-day bed reserve period. Payment shall be strictly voluntary, however, and shall be permitted only when the [recipient's] **beneficiary's** right to return to the NF (see N.J.A.C. [10:63]**8:85**-1.4) has been fully explained to the [recipient] **beneficiary** and his representative. The [recipient's] **beneficiary's** request to use the PNA for this purpose shall be in writing. Under no circumstances shall the facility use overt or implicit coercion in this matter.

(f) A uniform accounting system shall be maintained by the facility as follows:

1. In compliance with Federal and State rules and regulations the NF shall accept fiduciary responsibilities for a Medicaid [recipient's] **beneficiary's** PNA if the [recipient] **beneficiary** and/or authorized representative requests that his or her PNA be managed by the facility. The NF shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each [recipient's] **beneficiary's** personal funds entrusted to the facility on the [recipient's] **beneficiary's** behalf. In compliance with Federal and State rules and regulations, the facility shall deposit any resident's personal funds in excess of $50.00 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts. The facility shall credit all interest earned on the resident's account to his or her account.

2. The PNA account and related supporting information, such as receipts, canceled check, bank statement, check register shall be maintained at the facility. The [Division] **Department** recommends that a direct deposit system be utilized.

3. (No change.)

4. A subsidiary ledger shall be established whereby each [recipient's] **beneficiary's** deposits and disbursements are recorded and the total of the

[recipient's] **beneficiary's** balances reconciled to the general ledger control account each month, or as last reported by the banking facility.

5. When recording the [recipient's] **beneficiary's** income in a cash receipts journal, the PNA shall be segregated from the available income applied to the cost of the [recipient's] **beneficiary's** care. Within five days of receipt, the PNA shall be deposited directly into the interest bearing checking or savings account restricted for PNA. The general ledger control account shall reflect a credit posting to indicate the total PNA received during the month. Each [recipient's] **beneficiary's** subsidiary ledger account shall also be posted to record the deposits to the appropriate account.

6. To facilitate the [recipient's] **beneficiary's** access to the PNA, a portion of the total cash may be transferred periodically from the segregated checking/savings account to a petty cash fund. [Such petty cash fund shall be maintained as an imprest fund.] The amount of the [imprest] fund shall be reasonable and necessary for the size of the facility and needs of the [recipients] **beneficiaries**.

7. In compliance with Federal and State rules and regulations, the facility shall provide, at least quarterly, to the [recipient] **beneficiary** and/or his or her authorized representative, an accounting of all transactions with regard to the PNA account. The amount of balance in the [recipient's] **beneficiary's** account

shall be available for the [recipient] **beneficiary** and/or his or her authorized representative on request.

8. Management of funds shall be as follows:

i. For [recipients] **beneficiaries** who are able to manage their funds, a family member must have authorization in writing from the [recipient] **beneficiary/authorized representative** for a specific amount before funds are disbursed from the PNA.

ii. [Recipients] **Beneficiaries** who are unable to manage their funds should have representative payees appointed.

iii. Family members should withdraw funds only on presentation of receipts showing items purchased for the [recipient] **beneficiary**, unless this appears to be a financial hardship for the family member.

iv. In cases where there is an outside representative payee, and the [recipient] **beneficiary** appears to be denied access to his **or her** PNA funds, or personal items are not being purchased for him **or her**, the facility shall take steps to ensure that the [recipient's] **beneficiary's** right to his **or her** PNA benefits is restored. Such steps may include warning letters to the representative payee, use of the NF attorney, and/or referrals

to the Office of the Ombudsman for Institutionalized Elderly and the Social Security Administration. In such cases, the facility may wish to request representative payeeship.

9. When drawing checks or cash to make disbursements from the [recipient's] **beneficiary's** PNA account, either an original invoice or a signed receipt from the [recipient] **beneficiary** or an authorized representative shall be retained by the facility and referenced to the [recipient's] **beneficiary's** account. The receipt must stipulate the use of the funds or specify the items purchased.

10. When the facility draws checks on behalf of a [recipient] **beneficiary** or reimburses the petty cash fund, disbursements of PNA shall be segregated from the operating expenses of the facility. At the end of each month, the general ledger control account shall be charged for the total PNA disbursed and each [recipient's] **beneficiary's** subsidiary ledger account shall reflect the monthly disbursements on that [recipient's] **beneficiary's** behalf.

11. Accumulated interest is the property of the [recipient] **beneficiary**. Although a [recipient's] **beneficiary's** PNA may not be used for banking service charges, interest from the account may be used for this purpose.

12. Upon discharge or transfer to another NF or other place of residence, the facility shall provide the [recipient] **beneficiary** with a final accounting statement

and a check in the amount of the [recipient's] **beneficiary's** close-out balance within seven working days of the transfer; however, a [recipient] **beneficiary** transferred to another NF shall be given the option of authorizing the sending facility in writing to transfer any balance to the [recipient's] **beneficiary's** account at the receiving facility. The transfer of a PNA account from one facility to another shall be documented in writing, with a copy given to the [recipient] **beneficiary** and/or his or her authorized representative. A [recipient] **beneficiary** discharged or transferred shall have the right to the return of his or her personal property, such as, television, radio or other items.

13. Unclaimed PNA funds left behind by a discharged [recipient] **beneficiary** who cannot be located or where the authorized representative cannot be located, shall be forwarded within 30 days to the Bureau of Administrative Control, Mail Code # 6, [CN] **P.O. Box** 712, Trenton, New Jersey 08625-0712.

14. Within 10 days after the death of a Medicaid [recipient] **beneficiary**, whether death occurred in the NF, in a hospital, or during a period of therapeutic leave, the NF shall send a written notice regarding the existence of PNA funds both to the CWA and the individual identified by the [recipient] **beneficiary** as the person to contact. A NF shall exercise all reasonable efforts to locate and notify any family, representative payee or interested person acting on behalf of the deceased Medicaid [recipient] **beneficiary.**

i. The facility shall advise the contact person or responsible person that any claims made for PNA funds must be directed to the NF. When no CWA claim exists, the executor(rix) or administrator(rix), upon presentation of a letter of administration from the County Surrogate's Office, must be issued a check made payable to the estate of the deceased Medicaid [recipient] **beneficiary** for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a [recipient] **beneficiary** dies intestate, leaving no surviving spouse, and the total value of the estate is less than $5,000; in such case, an affidavit of administration in accordance with N.J.S.A. 3B:10-4 is acceptable.

ii. (No change.)

iii. If no claim for PNA funds is made to the NF within 30 days of death, a check made payable to the "Treasurer, State of New Jersey" shall be forwarded to the Bureau of Administrative Control, Mail Code # 6, [CN] **P.O. Box** 712, Trenton, New Jersey 08625-0712. The following information shall be included:

(1) An identification of the funds as unclaimed PNA funds of the deceased Medicaid [recipient] **beneficiary**;

(2) [Recipient's] **Beneficiary's** name;

(3) – (4) (No change.)

(5) Amount enclosed for that [recipient] **beneficiary**.

iv. If a claim is received by the NF after the PNA funds have been forwarded to the Bureau of Administrative Control and within five years of the Medicaid [recipient's] **beneficiary's** death, the claim must be referred to the Bureau for processing. After five years, all claims received by the NF must be referred to the State Treasurer.

v. Any transactions involving distribution of a deceased Medicaid [recipient's] **beneficiary's** PNA funds must appear on the NF's record for audit purposes.

(g) Questions regarding personal needs allowance administration, for example, procedures, policy, or use of funds, should be directed to the [Director of the Medicaid District Office serving the NF] **Department:**

Division of Long Term Care Services

P.O. Box 367

Trenton, New Jersey 08625-0367

[10:63]**8:85**-1.17 Residents rights

(a)– (b) (No change.)

(c) The NF shall notify each resident of his or her right under State law to make decisions concerning his **or her** medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, [P.L.1991, c. 201] **N.J.S.A 26:2H-53 et seq.** and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and Department of Health **and Senior Services** licensing requirements at N.J.A.C. 8:39-9.5.

[10:63]**8:85**-1.18 Medicaid/Medicare

(a) The New Jersey Medicaid Program will reimburse for NF services provided to combination Medicare/Medicaid [recipients] **beneficiaries** only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions - see (f)1i below.)

1. – 2. (No change.)

(b) Only skilled nursing facilities (SNFs), as defined in N.J.A.C. [10:63] **8:85**-1.2, certified by the [Health Care Financing Administration (HCFA)] **Centers for Medicare & Medicaid Services (CMS)** and the New Jersey Department of Health **and Senior**

Services are eligible to be reimbursed by Medicare for services rendered consistent with all Medicare requirements.

(c) – (d) (No change.)

(e) When Medicare benefits are denied, terminated or exhausted, because of coverage limitations, Medicaid may be billed on behalf of eligible [recipients] **beneficiaries**, provided that:

1. - 2. (No change.)

(f) Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the facility's Medicaid Nursing Facility rate. If the Medicaid [recipient] **beneficiary** has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid [recipients] **beneficiaries**. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1. (No change.)

SUBCHAPTER 2. NURSING FACILITY SERVICES

[10:63]**8:85**-2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the [RSN] **professional staff designated by the Department**, based on a comprehensive needs assessment which demonstrates that the [recipient] **beneficiary** requires, at a minimum, the basic NF services described in N.J.A.C. [10:63]**8:85**-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/ behavioral and psychosocial conditions which require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living **(bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating).** Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate ADL may be classified as either independent, requiring some assistance, or totally dependent.

i. (No change.)

2. (No change.)

(b) All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health **and Senior Services** licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. [10:63] **8:85** -3.

(c) (No change.)

[10:63]**8:85**-2.2 Delivery of nursing services

(a) The NF shall provide 24-hour nursing services in accordance with the **Department's** minimum **licensing** standards set forth by the New Jersey Department of Health Long Term Care Facilities Licensing Standards, N.J.A.C. 8:39, which is incorporated herein by reference **and employ** the service-specific case mix system to classify recipients with similar care requirements and resource utilization[, the] **. The** NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides on the basis of the total number of residents multiplied by 2.5 hours/day; plus the total number of residents receiving each of the following services:

[1.	Tracheostomy	1.25 hours/day
2.	Use of respirator	1.25 hours/day
3.	Head trauma stimulation/advanced neuromuscular/orthopedic care	1.50 hours/day
4.	Intravenous therapy	1.50 hours/day

5.	Wound care	0.75 hour/day
6.	Oxygen therapy	0.75 hour/day
7.	Nasogastric tube feedings and/or gastrostomy	1.00 hour/day]

1.	**Wound care**	**0.75 hours/day**
2.	**Nasogastric tube feedings and/or gastrostomy**	**1.00 hours/day**
3.	**Oxygen**	**0.75 hours/day**
4.	**Tracheostomy**	**1.25 hours/day**
5.	**Intravenous therapy**	**1.50 hour/day**
6.	**Respiratory services**	**1.25 hour/day**
7.	**Head trauma stimulation/advanced neuromuscular/orthopedic care**	**1.50 hour/day**

[(b)Nursing service requirements in (a) above shall be classified and recorded for each individual Medicaid recipient on Section Q (see Appendix O, incorporated herein by reference) of the New Jersey Standardized Resident Assessment (SRA) instrument. Section Q shall be reviewed and revised to reflect changes in the recipient's nursing service requirements at the time of each mandated review and revision of the SRA during the comprehensive assessment process and development of the interdisciplinary care plan. Section Q is signed and dated by the registered professional nurse who completes the assessment. In the absence of necessary change to Section Q at the

time of review, the current form may be signed and redated indicating that no change in nursing service requirements was identified.]

[(c)] **(b)** The NF [provision of 2.5 hours/day] **level of nursing care** means services provided to Medicaid [recipients] **beneficiaries** who are chronically or sub-acutely ill and require care for these entities, disease sequela or related deficits.

[(d)] **(c)** The [2.5 hours] **NF level** of nursing care shall incorporate the principles of nursing process which consists of ongoing assessment of the [recipient's] **beneficiary's** health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the [recipient] **beneficiary**, shall perform, beginning on the day of admission, a comprehensive assessment of the [recipient] **beneficiary** to provide, communicate and record within the SRA: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

i. In addition to clinical observations and hands-on examination of the Medicaid [recipient] **beneficiary**, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be

coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (SRA) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the [recipient's] **beneficiary's** status, the NF shall complete a full comprehensive assessment involving the SRA. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs) to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan which documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the [recipient's] **beneficiary's** problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid [recipient] **beneficiary** and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid [recipient] **beneficiary** and shall include: physiological, psychological and environmental factors; [recipient] **beneficiary** /family education; and discharge planning. The

care plan shall be a documented, accessible record of individualized care which reflects current standards of professional practice and includes:

i.-iii. (No change.)

iv. The initial interdisciplinary care plan shall be completed and implemented within 21 days of admission and shall be reviewed regularly and revised as often as necessary, according to all significant changes in a [recipient's] **beneficiary's** condition and to attainment of and/or revisions in objectives as indicated. Review and appropriate revision shall be done at least every three months and whenever the clinical status of the [recipient] **beneficiary** changes significantly or requires a change in service provision.

3. Implementation of the interdisciplinary care plan and delivery of nursing care shall be documented within nursing progress (clinical) notes, which shall establish a format for recording significant observations or interaction, unusual events or responses, or a change in the Medicaid [recipient's] **beneficiary's** condition, which requires a change in the scope of service delivery. Specific reference shall be made to the [recipient's] **beneficiary's** reactions to medication and treatments, rehabilitative therapies, additional nursing services in accordance with N.J.A.C. [10:63] **8:85** -2.2(a), observation of clinical signs and symptoms, and current physical, psychosocial and environmental problems.

Nursing entries shall be made as often as necessary, based on the Medicaid [recipient's] **beneficiary's** condition and in accordance with the standards of professional nursing practice.

4. Assessment review is the process of ongoing evaluation of health service needs and delivery. Nursing actions shall be analyzed for effectiveness of care plan implementation and achievement of objectives. The registered professional nurse, along with the Medicaid [recipient] **beneficiary** and/or significant other, shall participate with the team in the ongoing process of evaluation, reordering priorities, setting new objectives, revision of plans for care and the redirection of service delivery.

i. The assessment review process shall be conducted quarterly. Conclusions shall be documented on the SRA quarterly review, and the interdisciplinary care plan shall be updated to provide a comparison of the Medicaid [recipient's] **beneficiary's** previous and present health status, and to outline changes in service delivery and nursing interventions. The assessment review shall identify the effectiveness of, and the Medicaid [recipient's] **beneficiary's** response to, therapeutic interventions, and, whenever possible, the reason for any ineffectiveness in [recipient] **beneficiary** responses.

[(e)] **(d)** Restorative nursing is a primary component in [the delivery of the 2.5 hours] **the NF level** of nursing care. Restorative nursing addresses preventable deterioration and is directed toward assisting each [recipient] **beneficiary** to attain the highest level of physical, mental, emotional, social and environmental functioning. Restorative nursing functions shall include:

1.–11. (No change.)

[(f)] **(e)** (No change.)

[(g)] **(f)** Nursing services requiring additional nursing hours above **the** 2.5 hour[s/day] **staffing requirement** are set forth in [(g)] **(f)**1 through 7 below. An individual [recipient] **beneficiary** may require one or more additional nursing services, however, each category of additional nursing service may only be counted once for each individual [recipient] **beneficiary**.

1. (No change.)

2. Tube feedings (1.00 hr/day), which include nasogastric tube, and percutaneous feedings may be used **only** if the feedings [are required to treat the individual's condition after] **are providing the individual with 51 percent or more calories or 26 to 50 percent calories and 501 cubic centimeters or more of enteral fluid intake per day and** all non-invasive avenues to improve

the nutritional status have been exhausted with no improvement. The clinical record shall document the non-invasive measures provided and the individual's poor response. The record shall also indicate the medical condition for which the feedings are ordered. Included in this service is the routine care of the tube site and surrounding skin of the surgical gastrostomy.

i. Feeding tubes that [are routinely clamped off and are no longer the primary source of] **do not meet the** dietary administration and nutritional support **criteria as stated in (g)2 above** are covered under the basic [2.5 hours/day of] nursing service and shall not be counted as an additional nursing service.

[3. Oxygen therapy (.75 hrs/day), which includes complex provision of oxygen/respiratory therapies due to the nature of the individual's condition, type or multiplicity of procedures required and the need for therapies for which individual is dependent upon administration by licensed staff such as positive pressure breathing therapy, nasal BiPAP and aerosol therapy.]

3. Oxygen therapy (.75 hrs/day), which includes the provision of continuous oxygen therapy to increase the saturation of hemoglobin (Hb) without risking oxygen toxicity in beneficiaries with airway obstructive conditions such as asthma, chronic obstructive pulmonary disease or heart failure. The beneficiary requires continuous pulse oximetry

monitoring. The licensed nurses assess lung function and the beneficiary's symptoms that require intervention by the physician, physician assistant or advanced practice nurse.

4. Tracheostomy (1.25 hrs/day), which includes new tracheostomy sites and complicated cases involving symptomatic infections and unstable respiratory functioning **and deep suctioning**.

5. Intravenous Therapy (1.50 hrs/day), which includes clinically indicated therapies ordered by the physician, such as central venous lines, Hickman/Broviac catheters, heparin locks, total parenteral nutrition, elysis, hyperalimentation and peritoneal dialysis. **This includes the flushing and dressing of the central venous lines.** When clinically indicated, intravenous medications should be appropriately and safely administered within prevailing medical protocols. If intravenous therapy is for the purpose of hydration, the clinical record shall document any preventive measures and attempts to improve hydration orally, and the individual's inadequate response.

[6. Respirator use (1.25 hrs/day), which includes care for individuals who are stable and no longer require acute or specialized respirator programs and who require mechanical ventilation to oxygenate their blood. Ongoing assessment and intervention by a licensed nurse is needed. The individual's treatment plan

should include protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician.]

6. Respiratory services (1.25 hrs/day), which includes the provision of respiratory services for which the individual is dependent upon licensed nursing staff to administer, such as positive pressure breathing therapy, nasal Bilevel Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP) and aerosol therapy. The use of hand held inhalation aerosol devices is not included in this add-on service.

7. (No change.)

[10:63]**8:85**-2.3 Physician services

(a) General requirements for physician services shall be as follows:

1. Each Medicaid [recipient's] **beneficiary's** care shall be under the supervision of a New Jersey licensed attending physician chosen by, or agreed to by, the Medicaid [recipient] **beneficiary**, or if the [recipient] **beneficiary** is incompetent, by the family or legal guardian.

2. - 3. (No change.)

(b) Requirements for a medical director shall be as follows:

1. (No change.)

2. The duties of the medical director shall include, but not be limited to, the following:

i. - xii. (No change.)

xiii. Ensuring that, for each Medicaid [recipient] **beneficiary**, there is a designated primary and alternate physician who can be contacted when necessary.

(c) Requirements for an attending physician shall be as follows:

1. (No change.)

2. The attending physician shall also be responsible for initial and ongoing medical evaluation, as follows:

i. The medical assessment of the Medicaid [recipient] **beneficiary** shall begin at the time of admission to a NF and shall be the foundation for the planning, implementation, and evaluation of medical services directed toward the care needs of the resident.

ii. The medical assessment shall consist of the complete, documented, and identifiable appraisal (from the time of admission to discharge) of the Medicaid [recipient's] **beneficiary's** current physical and psychosocial health status. The medical assessment shall be utilized to determine the existing and potential requirements of care. The evaluation of the data obtained from the medical assessment shall lead to the development of the medical services portion of the interdisciplinary care plan. The assessment data shall be available to all staff involved in the care of the resident.

iii. (No change.)

iv. Other Medicaid [recipient] **beneficiary** data utilized should include:

(1) - (15) (No change.)

v. (No change.)

(1) – (8) (No change.)

vi. As an active member of the interdisciplinary team, the attending physician shall:

(1) Identify and document the medical needs of the Medicaid [recipient] **beneficiary**;

(2) (No change.)

(3) Be observant of clinical signs and symptoms of the Medicaid [recipient] **beneficiary**;

(4) (No change.)

(5) Periodically evaluate and be cognizant of the Medicaid [recipient's] **beneficiary's** total clinical record including the interdisciplinary care plan and facilitate necessary changes as medically indicated;

(6) Identify and document the effectiveness of, and the Medicaid [recipient's] **beneficiary's** response to, therapeutic intervention such as medications, treatment and special therapies, and, where possible, the reason for any ineffectiveness in the Medicaid [recipient's] **beneficiary's** responses.

3. Physician progress notes shall:

i. Be maintained in accordance with accepted professional standards and practices as necessitated by the Medicaid [recipient's] **beneficiary's** medical condition;

ii. Be a legible, individualized summary of the Medicaid [recipient's] **beneficiary's** medical status and reflect current medical condition, including clinical signs and symptoms; significant change in physical or mental conditions; response to medications, treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for extent of change in the medical treatment plan; and

iii. (No change.)

4. (No change.)

5. Physician visits shall be conducted as follows:

i. All required physician visits shall be made by the physician personally, or a physician assistant or nurse practitioner, as permitted by state law.

(1) For the first 90 days, the Medicaid [recipient] **beneficiary** shall be visited and examined every 30 days. Thereafter, with written

justification, the interval between visits may be extended for up to 60 days.

(2) Additional visits shall be made when significant clinical changes in the Medicaid [recipient's] **beneficiary's** condition require medical intervention.

[10:63]**8:85**-2.4 Rehabilitative services

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology services provided by a qualified therapist for the purpose of attaining maximum reduction of physical or mental disability and restoration of the resident to his **or her** best functional level. Rehabilitative services shall be made available to Medicaid [recipients] **beneficiaries** as an integral part of an interdisciplinary program. Rehabilitative services shall not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a qualified therapist.

1. - 4. (No change.)

[10-63]**8:85** -2.5 (No change in text.)

[10:63]**8:85**-2.6 Social services

(a) - (h) (No change.)

(i) Social services discharge planning shall be as follows:

1. - 3 (No change.)

4. The social worker shall consult the HSDP on admission to determine the recommendations of the [Medicaid RSN] **professional staff designated by the Department** concerning discharge and to identify Track II residents.

5. (No change.)

6. Discharge planning shall be carried out by means of an interdisciplinary care plan that includes goals and time frames. Social work intervention geared towards discharge shall be recorded as interim notes. The discharge plan shall include:

i.- iii. (No change.)

iv. Specific financial assistance needed by the [recipient] **beneficiary**; and

v. (No change.)

7. – 10. (No change.)

(j) (No change.)

[10:63]**8:85**-2.7 Pharmaceutical services; general

(a) - (d) (No change.)

(e) Signed physicians' orders for medications, drugs, tests, diet, and treatment administered to Medicaid [recipients] **beneficiaries** must be accurately recorded on the [recipient's] **beneficiary's** chart with review and update as required.

(f) All services required of a Consultant Pharmacist in NFs, as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed in this subsection shall be provided.

1. Responsibilities of the consultant pharmacist shall be as follows:

i. -iii. (No change.)

iv. Assure that [recipients'] **beneficiaries'** medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physician's orders and established stop-order policies;

v. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same [recipient] **beneficiary**, are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;

vi. Review the drug regimen (that is, the dosage form, route of administration and time of administration) of each [recipient] **beneficiary** at least monthly and **prepare a written** report **of** any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate. Irregularities in the administration of medications shall also be reported promptly to the Director of Nursing.

vii. Report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a

summary of the review of each [recipient's] **beneficiary's** drug regimen and clinical record and the consultant pharmacist's findings and recommendations;

viii. - xi. (No change.)

[10:63]**8:85**-2.8 Consultations and referrals for examination and treatment

(No change in text.)

[10:63]**8:85**-2.9 Mental health services

(a) All facilities shall assist Medicaid [recipients] **beneficiaries** to obtain mental health care through a licensed psychiatrist or psychologist, who shall provide, or make provision for, routine and emergency services.

(b)-(d) (No change.)

[10:63]**8:85**-2.10 Dental services

(a) All facilities shall assist Medicaid [recipients] **beneficiaries** to obtain dental care though a licensed dentist, who shall provide, or make provision for:

1. - 4. (No change.)

(b) Dental examinations carried out to comply with the Department of [Health's] **Health and Senior Services'** minimal requirements, **as defined in N.J.A.C. 8:39-15.1,** as well as regular dental examinations, shall not be considered consultations and need not be brought to the attending physician's attention except as a matter of courtesy. However, treatments which involve invasive procedures such as extractions or fillings, except in an emergency, shall be brought to the attention of the attending physician who acknowledges clearance for such treatment on the order sheet.

(c)-(e) (No change.)

[10:63]**8:85**-2.11 Podiatry services

(a) All facilities shall assist Medicaid [recipients] **beneficiaries** to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

1. - 4. (No change.)

(b)-(c) (No change.)

[10:63]**8:85**-2.12 Chiropractic services

All facilities shall assist Medicaid [recipients] **beneficiaries** to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for routine and emergency services.

[10:63]**8:85**-2.13 Vision care services

(a) All facilities shall assist Medicaid [recipients] **beneficiaries** to obtain vision care through a licensed ophthalmologist or optometrist who shall provide, or make provision for, routine and emergency services.

(b) (No change.)

[10:63]**8:85**-2.14 Laboratory; X-ray, portable X-ray and other diagnostic services

(a) A NF shall have written agreements with one or more general hospitals or one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly. If the facility has its own laboratory capabilities, the services may not be billed on a separate fee-for-service basis. A laboratory must be:

1. Licensed and/or approved by the New Jersey State Department of Health **and Senior Services** and the State Board of Medical Examiners **,** which includes meeting Certificate of Need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey Sanitary Code; and

2.-3. (No change.)

(b) (No change.)

(c) A NF shall have written agreements with one or more general hospitals or one or more qualified providers so that the facility can obtain other diagnostic services, such as ECG, EEG, CAT scan, MRI and ultrasonogram, including emergency services, promptly.

1. (No change.)

2. All findings and reports shall be recorded in the [recipients] **beneficiary's** clinical record.

[10:63]**8:85**-2.15 Medical supplies and equipment

(a) - (b) (No change.)

(c) Routinely used durable medical equipment ordered for Medicaid [recipients] **beneficiaries** in a participating NF (for example, walkers, wheelchairs, bed-rails, crutches, traction apparatus, **intermittent positive-pressure breathing (**IPPB**)** machine, electric nebulizers, electric aspirators, low-end pressure relief systems such as mattress overlays and mattress replacements, powered mattress systems and powered flotation beds) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its residents shall be considered part of the NF's cost, and shall not be billed directly to the program by the supplier.

(d) When unusual circumstances require special medical equipment not usually found in a NF, such special equipment may be reimbursable, with prior authorization from the [Medicaid District Office] **Medical Assistance Customer Center (MACC)** serving the county where the facility is located.

1. When special medical equipment is authorized and purchased on behalf of a Medicaid [recipient] **beneficiary**, ownership of such equipment shall vest in the Division of Medical Assistance and Health Services **(DMAHS)** . The [recipient] **beneficiary** shall be granted a possessory interest for as long as the [recipient] **beneficiary** requires use of the equipment. When the [recipient] **beneficiary** no longer needs such equipment, possession and control shall revert to [the Division] **DMAHS** . The [recipient] **beneficiary** shall agree to this when he or she signs the "patient's certification" section on the claim form. The NF shall notify the [MDO] **MACC** in writing when such equipment is no longer in use.

2. Prior authorization requests for special medical equipment shall be accompanied by documentation from the attending physician, the registered professional nurse who has primary responsibility for the [recipient] **beneficiary**, and appropriate rehabilitative therapy personnel, which relates the medical necessity for the equipment and describes the extraordinary requirements of the [recipient] **beneficiary**.

3. Pressure relief systems shall be reimbursed in a NF under the following conditions:

i. Air Fluidized and Low Air Loss therapy beds, as defined in N.J.A.C. [10:63]**8:85**-1.2, shall be considered special medical equipment and shall be prior authorized for reimbursement in a NF only when all of the following criteria, indicating medical necessity, are documented by the physician.

(1) The [recipient] **beneficiary** has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, sacrum.

(2) The [recipient] **beneficiary** with coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) presents post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(3) The [recipient] **beneficiary** is bedridden or chair-bound as a result of severely limited mobility.

(4) The [recipient] **beneficiary** is receiving maximal medical/nursing care, prior instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

(5) The bed is ordered, in writing, by the attending physician based on his or her comprehensive assessment (which includes a physical examination) and evaluation of the [recipient] **beneficiary**.

(6) (No change.)

ii. (No change.)

iii. Prior authorization of air fluidized or low air loss therapy beds, if approved, shall be granted for 30 days only. Continued use beyond the initial approval period shall require prior authorization on a monthly basis. The following information shall be submitted to the [MDO] **MACC** to obtain prior authorization:

(1)- (7) (No change.)

(8) Photographs of the site upon permission of the [recipient] **beneficiary**/family, after full due consideration is afforded to the

[recipient's] **beneficiary's** right to privacy, dignity and confidentiality.

iv. After treatment with an air fluidized or low air loss therapy bed is initiated, the [recipient] **beneficiary** shall:

(1) (No change.)

(2) Remain on the therapy unit and be confined to bed, unless medically necessary. While confined to bed, due consideration shall be given to the [recipient's] **beneficiary's** need for social and sensory stimulation and recreational diversion by providing in-room visitation and social/recreational activities appropriate to the [recipient's] **beneficiary's** condition; and

(3) (No change.)

v. Professional staff from the [MDO] **MACC** may, at their discretion, perform an onsite visit to evaluate the [recipient] **beneficiary** prior to or after therapy has been instituted. Continued approval shall be contingent upon the facility's compliance with the criteria and conditions defined in (d)3i, ii, iii and iv above and cooperation of the [recipient] **beneficiary** to the therapeutic modality.

[10:63]**8:85**-2.16 (No change in text.)

[10:63]**8:85**-2.17 Transportation services

(a) The NF shall assist a Medicaid [recipient] **beneficiary** in obtaining transportation when the [recipient] **beneficiary** requires a Medicaid-covered service or care not regularly provided by the NF.

(b) – (c) (No change.)

(d) Invalid coach services shall not require prior authorization from the [MDO] **MACC**.

1. (No change.)

2. An invalid coach may be utilized when a Medicaid [recipient] **beneficiary** requires transportation from place to place for the purpose of obtaining a Medicaid-covered service and when the use of an alternative mode of transportation, such as a taxi, bus, livery, or private vehicle would create a serious risk to life or health.

(e) Transportation by taxi, train, bus and other public conveyances shall not be directly reimbursable by the New Jersey Medicaid program. Inquiry should be made to the County Welfare Agency **(CWA)** for authorization and payment for such transportation.

(f) (No change.)

[10:63]**8:85**-2.18 Bed and board

(a) Beds are provided in rooms licensed by the New Jersey Department of Health **and Senior Services**. A NF providing care to children shall have available protective cribs for infants and small children, as well as appropriate furniture, sized and scaled for children.

(b) (No change.)

[10:63]**8:85**-2.19 (No change in text.)

[10:63]**8:85**-2.20 Non-covered services

(a) [Non-covered services in NFs shall include, but not be limited to the following] **Medicaid beneficiaries residing in NFs shall not be eligible to receive Medicaid reimbursement for the following services**:

1.– 4. (No change.)

5. Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interested in the NF; [or]

6. Partial care services in independent clinics**; or**

7. Medical/social day care.

[10:63]**8:85**-2.21 Special care nursing facility (SCNF)

(a) A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the [Division of Medical Assistance and Health Services] **Department of Health and Senior Services** to provide care to New Jersey Medicaid [recipients] **beneficiaries** who require [specialized] **intensive** nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. [10:63]**8:85**-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

1. The minimum bed requirement [shall] **will** be waived for SCNFs that were approved by [the Division] **DMAHS** prior to [the adoption of this regulation] **November 23, 1994**. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health **and Senior Services**.

2. A SCNF receiving reimbursement through the Medicaid program shall not increase its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department.

[2.] **3.** A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24-hour basis. [Length of stay in a SCNF shall be determined by the individual's progress and the overall response to the therapeutic regimen.]

(b) A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and [specialized] needs of the target population [of the SCNF].

1. Within a focused[, specialized] therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:

i.-iii. (No change.)

(c) A SCNF shall provide services to Medicaid [recipients] **beneficiaries** who have been determined, through the PAS process, to require extended rehabilitation and/or complex care. **The individual's progress and overall response to the therapeutic regimen shall determine length of stay.**

1. (No change.)

2. Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by [a] **an** interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population [of the SCNF]. The individual may remain for a period of up to [2] **two** years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.

3. Medicaid [recipients] **beneficiaries** who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d) Discharge procedures shall include utilizing Medicaid discharge protocols established by [N.J.A.C. 10:63] **this chapter**, and **shall be in accordance with** the following:

1. The [recipient] **beneficiary** shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of

functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.

2. (No change.)

3. [In the case of a recipient] **When a beneficiary** residing in a SCNF unit of a conventional NF [who] is determined by [Division] **Department** staff to no longer require special programming, yet continues to require conventional NF services, [such a recipient] **the beneficiary** shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another **conventional nursing** facility. The SCNF shall be afforded 30 to 60 days from [then] **the** date of the determination to effect transfer of the [recipient] **beneficiary** to a bed within the [facilities] **facility's** conventional bed allocation or arrange transfer to another conventional NF.

(e) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. [10:63]**8:85**-2.3, with the following modifications and/or additions:

i. A freestanding SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical

diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a [specialty] medical group provides medical services [to the SCNF], a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in **(e)1i** above, a freestanding SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to [the effective date of these rules] **November 23, 1994**.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population [of the SCNF];

iii. (No change.)

2. A SCNF shall provide those nursing services as defined in N.J.A.C. [10:63]**8:85**-2.2 with the following modifications and/or additions:

i. A freestanding SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New

Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or long-term care setting.

(1) In lieu of **the education and experience requirements of** (e)2i above, [serve] **the director of nurses or nursing administrator shall have served** [as director of nursing] **in that capacity** prior to [the adoption of these regulations] **November 23,1994.**

(2) A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit. [The SCNF unit shall have six months from the date of adoption of these rules to comply with this requirement.]

ii. (No change.)

iii. Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. [10:63]**8:85**-2.2 **shall be provided per beneficiary per day**. Additional nursing services **in a SCNF** up to a maximum of three hours may be provided due to technically complex nursing needs and/or

intensive rehabilitative/restorative nursing care needs. **A SCNF which is an identifiable unit within a conventional NF shall calculate the nurse staffing level separate and apart from the nurse staffing level of the conventional beds.**

iv. Provision of additional nursing services (acuities) as defined in N.J.A.C. [10:63]**8:85**-2.2 does not apply to nurse staffing rules in a SCNF. **The additional nursing services (acuities) described at N.J.A.C. 8:85-2.2(a) are included in the three hours**.

(1) (No change.)

v. (No change.)

3. A SCNF shall provide those social services as required by N.J.A.C. [10:63]**8:85**-2.6, with the following modifications and/or additions:

i. – iii. (No change.)

iv. Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) – (3) (No change.)

(4) Coordinate [SCNF] programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5) (No change.)

4. A SCNF shall provide resident activities required by N.J.A.C. [10:63]**8:85**-2.5, with the following modifications and/or additions:

i. The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1) In lieu of (e)4i above, [serve] **the individual shall have served** as director of resident activities prior to [the adoption of these rules] **November 23,1994**; or

(2) (No change.)

ii. – iv. (No change.)

5. A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. [10:63]**8:85**-2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i. -ii. (No change.)

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. [10:63] **8:85**-2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults [,] shall provide respiratory therapy services beyond the scope of N.J.A.C. [10:63]**8:85**-2, which shall include, but not be limited to:

i. – iii. (No change.)

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1) - (5) (No change.)

(6) Drawing and analyzing samples of arterial, capillary and venous blood; [and/or]

(7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals[.]**;**

(8) Assessment, intervention, and evaluation by a registered professional nurse; and/or

(9) Protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician or advanced practice nurse.

SUBCHAPTER 3. COST [STUDY] **REPORT**, RATE REVIEW GUIDELINES AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

[10:63]**8:85**-3.1 Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey, **Department of Health and Senior Services (Department),** to establish prospective per diem rates for the provision of nursing facility services to residents under the State's

Medicaid program. [These rules have been developed jointly by the State Department of Human Services and the State Department of Health ("the departments").]

(b) The [departments believe] **Department believes** that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The [departments recognize] **Department recognizes**, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the [departments are] **Department is** prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the [departments reserve] **Department reserves** the right to question and exclude [from] any unreasonable costs, consistent with the provision of N.J.S.A. 30:4D-1 et seq.

(e) - (f) (No change.)

[10:63]**8:85**-3.2 [Timing] **Cost report preparation and timing of submission**

(a) [Commencing with fiscal year ending with November 30, 1977, NFs] **Nursing facilities** shall furnish required cost [studies] **reports** to the Department of Health **and Senior Services**, [Health Facilities Rate Setting] **Office of Nursing Facility Rate Setting and Reimbursement,** within 90 days of the close of each fiscal year. For [rate review purposes] **the purpose of this subchapter**, the period for which these actual data are reported will constitute the "base period" for establishing prospective per diem reimbursement rates commencing six months after the end of the base period. These rates will not be subject to routine retroactive adjustments except for matters specified in this subchapter. As required by Federal regulations at 42 CFR 447.304, prospectively determined payment rates will be redetermined at least annually.

(b) - (c) (No change.)

(d) The [Director, Division of Medical Assistance and Health Services] **Assistant Commissioner, Division of Senior Benefits and Utilization Management**, or a designee of the [Director] **Assistant Commissioner**, may mitigate or waive the penalties specified in (b) above, for “good cause” shown:

1. – 2. (No change.)

3. All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the [Director] **Assistant Commissioner** may require.

(e) The penalty rates indicated in (b) above will be applied to cost [studies] **reports** commencing with the reporting periods ending May 31, 1980.

(f) A nursing facility cost report cannot be substituted or revised by a NF except during the 30 calendar days after the original due date of the cost report to the Department of Health **and Senior Services**, [Health Facilities Rate Setting] **Nursing Facility Rate Setting and Reimbursement**. However, such substitution or revision can be made if it would prevent an overpayment to the NF.

[10:63]**8:85**-3.3 Rate components

(a) The prospective rates will be "screened" rates per day calculated by applying standards and reasonableness criteria ("screens") for three classes of NFs:

1. (No change.)

2. Class II Governmental NFs:

i. To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the [Division of Medical Assistance and Health

Services] **Department of Health and Senior Services** and be a governmental operation.

3. Class III (Special Care) Nursing Facilities (SCNFs).

i. To qualify as a SCNF, the NF must meet all of the contractual requirements [of the Division of Medical Assistance and Health Services] and be approved by the [Division] **Department** as a SCNF.

ii. SCNFs shall be grouped by**:** [the following types for separate screening purposes:]

(1) - (6) (No change.)

(b) - (c) (No change)

1.– 3. (No change)

(d) The development of the "screens" for Class I, Class II, and Class III NFs includes the governmental NFs' and SCNFs' reported costs and statistics in the following areas:

1. - 3. (No change.)

(e)- (f) (No change.)

(g) A provision for inflation will be added to reasonable base period costs in calculating the prospective rates as described in N.J.A.C. [10:63] **8:85**-3.19.

(h) - (k) (No change.)

[10:63]**8:85**-3.4 (No change in text.)

[10:63]**8:85**-3.5 Raw food costs

(a) Raw food costs per patient day for voluntary and proprietary NFs which provide their own food service and which had over 20 percent Medicaid patient days in the base period will be determined. NFs [which] **that** contract for their dietary operations will be excluded. These per diem costs will be ranked in descending order on a Statewide basis. The reasonableness limit will be set at 120 percent of the median cost per day.

1. – 2. (No change.)

(b) For NFs below this limit, prospective rates will be based upon actual costs. Where homes report unit costs 15 percent or more below the median, the Department [of Health, Health Facilities Inspection] will [be asked to] inspect the food operations for compliance with State standards.

(c) (No change.)

[10:63]**8:85**-3.6 General services expenses

(a) (No change.)

(b) The bases for screen development and reported costs subject to applicable screens [,] are as follows:

1. Food: As indicated in N.J.A.C. [10:63]**8:85**-3.5.

2. – 4. (No change.)

(c) (No change.)

[10:63]**8:85**-3.7 Property operating expenses

(a) Property operating expenses include property taxes and utilities.

1. (No change.)

2. For this purpose, reasonable plant square feet (and related property taxes) [is] **are** determined as follows:

i.-ii. (No change.)

iii. The reasonableness limit for each NF's plant square feet shall be established at 110 percent of the base for its licensed beds. ([see] **See** N.J.A.C. [10:63]**8:85**-3.11 for NFs with residential or sheltered care patients).

3. For NFs whose plant square feet exceeds this limit, the property taxes related to the excess will be excluded from the rate base. For this purpose, it will be assumed that assessed values for buildings vary directly in relation to their areas. The latitude set forth in [paragraph] **(a)**2iii [of this subsection] **above** is intended to provide for inequities that could result from this assumption. The [department] **Departmen**t will review**,** on an individual basis, any additional inequities which owners believe are brought about by unusual circumstances.

4. For NFs whose appraised value per plant square foot (as determined by an agent designated by the State) is greater than 110 percent of the median construction costs at 1977 price levels, the property taxes attributable to the excess will be excluded from the rate base unless the owners can demonstrate unusual circumstances. For screening new NFs, this figure will be revised each year for inflation and for effects of standards changes upon construction cost.

(See N.J.A.C. [10:63]**8:85**-3.11 for the methodology for calculating this limit at 1977 price levels.)

5.-6. (No change.)

7. After making any adjustments per (a)6 above, taxes [bases] **based** upon land appraisals in excess of 140 percent of the median appraisal value of five acres, rural, and two acres, urban, of all NFs in the county will also be considered unreasonable. In the case of counties with fewer than five NFs**,** neighboring counties may be combined in determining the median value to be used.

8. (No change.)

(b) (No change.)

(c) Utility costs will be screened for reasonableness as follows:

1. Base period utility costs per bed will be deemed unreasonable to the extent that they exceed 125 percent of the Statewide median cost per bed, as determined for each class type of NF indicated in N.J.A.C. [10:63] **8:85** –3.3.

i. (No change.)

[10:63]**8:85**-3.8 Special amortization

(a) The [departments] **Department** will consider on an individual basis, the amortization of start-up costs and special expenditures in rates. Each case will be reviewed on its particular merits and, accordingly, no guidelines are specified herein. As a rule, however, provisions for special amortization would relate to expenditures of a capital nature that are mandated by changes in law and regulations. The amortization period would generally range from 12 to 60 months, depending upon the nature and magnitude of expenses.

(b) In approving the amortization of special expenditures, the [departments] **Department** will also consider the extent to which a NF's rates are based on capital and cost levels of fully complying NFs, or, for capital items, a review of a minimum of three bids on the acquisition or project.

[10:63]**8:85**-3.9 Routine patient care expenses

(a) (No change)

(b) Reasonableness limits for nursing services ([RN's, LPN's] **RNs, LPNs** and other) will be established as follows:

1. The minimum nursing requirements in terms of hours worked will be calculated for each Class I and Class II NF based upon [the case mix patient classification (see N.J.A.C. 10:63-3.9(b)1ii(2) and standards in effect during the

base period. Minimum nursing requirements in terms of hours shall be calculated for each NF based upon]:

i. The number of patient days **reported on the cost report** during the base period;

[ii. The base period patient mix related to additional nursing services requiring additional minimum nursing time as derived from patient counts reported by each facility to the Medicaid fiscal agent:

(1) Patients with conditions requiring additional nursing services will be reported by means of the billing turnaround document (TAD) for Medicaid recipients, and the Medicaid billing certification document for non-Medicaid patients. If a facility fails to report a condition requiring additional nursing services on the original TAD or billing certification document, the count will not be used in the facility's rate calculation.

(2) Facilities will report patients with conditions requiring additional nursing services if a patient: resided in the facility and had the condition(s) for the entire month; resided in the facility for the entire month and developed the condition(s) during that month; or entered the facility and had the condition(s) for some portion of

the month. This count shall include patients who develop condition(s) during a month or enter the facility with condition(s) and cease to have this condition, are discharged, or die during the same month. No reporting shall be made for a patient who ceased to have the condition(s), died or left the facility during a month (other than the month of admission or onset of the condition(s)), except for a patient who was on a bed hold leave to an acute care hospital and returned to the facility.

iii. The State Department of Health minimum nurse staffing standards, according to N.J.A.C. 8:39-25.]

ii. The minimum nurse staffing standards of 2.5 hours/day in accordance with N.J.A.C. 8:39-25 during the base period; and

iii. The total number of residents reported on the cost report that were receiving additional nursing services based on the following acuities during the base period:

1.	**Wound care**	**0.75 hours/day**
2.	**Nasogastric tube feedings and/or gastrostomy**	**1.00 hours/day**
3.	**Oxygen**	**0.75 hours/day**

4.	Tracheostomy	1.25 hours/day
5.	Intravenous therapy	1.50 hour/day
6.	Respiratory services	1.25 hour/day
7.	Head trauma stimulation/advanced neuromuscular/orthopedic care	1.50 hour/day

(1) The month of onset of additional nursing services should be counted as one full month, whether the services are continued or discontinued before the end of the month. After the first month, count the patient only if the additional services are being provided at the end of the next month. If the need for additional nursing services ceases during the month following the month of onset, that month is not counted. However, as stated above, the month of onset is counted as one full month.

(2) If the patient, who requires additional nursing services, dies in the same month as the onset of the services, the patient is counted.

(3) Count the patient requiring additional nursing services if they are on 10-day bed hold or therapeutic leave at the end of the calendar month as though they are still in the facility.

If the patient requiring additional nursing services is on bed hold or therapeutic leave in one calendar month and it extends into the following month, and the patient either does not return to the same facility or goes beyond the bed hold allowance through that following month, the additional nursing services are not counted in that following month. When the same patient requiring additional services returns to the same facility or another facility, the additional nursing services are counted in the readmission/admission calendar month, provided the need for additional nursing services persists through that calendar month.

iv. (No change.)

2. – 4. (No change.)

5. The average equalized hourly compensation rate of each type of nurse (see N.J.A.C. [10:63] **8:85**-3.4) will be calculated separately for Class I, Class II, and each type of Class III facility.

i. (No change.)

6. – 7. (No change.)

(c) (No change.)

(d) Reasonableness limits for medical supplies and patient activities will be established at:

1. – 2. (No change.)

3. 150 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs.

i. For Class III NFs which are approved as a combination of [ventilator/respirator] **Ventilator/Respirator** type and some other SCNF type listed at N.J.A.C. [10:63] **8:85** –3.3(a)3ii, the reasonable limit for medical supplies will be determined by multiplying applicable patient days (ventilator patient days versus a [non-ventilator/respirator] **non-Ventilator/Respirator** SCNF-type patient days) times the appropriate medical supplies screen (ventilator versus a non-ventilator/respirator SCNF type) and adding the products, as follows:

	(1) Base period Patient Days	(2) Limit Per day	(3) Total (1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(e) Reasonableness limits for medical director, pharmaceutical consultant, non-legend drugs, social services and oxygen will be established at:

1. – 2. (No change.)

3. 110 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs, except as provided in (e)3i and ii below:

i. (No change.)

ii. For Class III NFs which are approved as a combination of a Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. [10:63]**8:85**-3.3(a)3, reasonable limits for oxygen will be determined by multiplying applicable patient days (ventilator patient days versus a non-ventilator/respirator SCNF type patient days) times the appropriate oxygen screen (ventilator versus a non-ventilator/respirator type SCNF) and adding the products, as follows:

	(1) Base period Patient Days	(2) Limit Per day	(3) Total (1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(f) Where actual base period costs for routine patient care are below the limits established, the actual costs will be included in the rate base. The Department of Health **and Senior Services** , [Health Facilities Inspection] **Long Term Care Assessment and Survey as authorized at N.J.A.C. 8:39**, will be notified of all cases where [a] NF patient care costs per day are less than 75 percent of the **respective** limit[s] in N.J.A.C. [10:63-3.8(b)6] **8:85-3.5 and 3.9** and [of all cases] **in each case** where nursing hours worked appear to be below **the** State standards.

[10:63]**8:85**-3.10 Property — capital costs

(a) (No change.)

(b) The rules promulgated herein have been developed with the following objectives and considerations:

1. The [departments] **Department** should not concern [themselves] **itself** with the method and attendant costs with which individual[s] NFs are financed and constructed or the arrangements under which they are acquired or leased.

2. While not concerning [themselves] **itself** about the costs, financing and so forth, of individual NFs**,** the [departments] **Department's** mandate with respect to the reasonableness of cost requires it to develop this rate component upon the presumption of reasonable facility costs and prudent financing.

3. (No change.)

(c) The [departments believe] **Department believes** that the above objectives can best be met by establishing an aggregate "capital facilities allowance" (CFA). The aggregate annual CFA for building, land, and movable equipment shall constitute the maximum reasonable reimbursement for depreciation (except automobiles), rentals of buildings and equipment (except automobiles), interest on all indebtedness, and amortization of leasehold improvements. Reimbursement shall be limited to the lower of:

1. – 2. (No change.)

(d) The following considerations will be addressed in determining the CFA:

1. Buildings (see N.J.A.C. [10:63] **8:85**-3.11);

2. Land and land improvements (see N.J.A.C. [10:63]**8:85**-3.12);

3. Equipment (routine moveable) (see N.J.A.C. [10:63]**8:85**-3.13);

4. Maintenance and replacements (see N.J.A.C. [10:63]**8:85**-3.14);

5. Property insurance (see N.J.A.C. [10:63]**8:85**-3.15);

6. Economic occupancy level (see N.J.A.C. [10:63]**8:85**-3.16).

[10:63]**8:85**-3.11 (No change.)

[10:63]**8:85**-3.12 Land

(a) The CFA for land will be based upon appraised value of land and land improvements determined by an agent designated by the State of New Jersey as follows:

1.-5. (No change.)

6. The Department shall establish a reasonableness limit on the amount of reimbursement that an NF shall receive for the land component of its CFA. Reasonableness limits for land and land improvements will be the same as defined for property taxes on land at N.J.A.C. [10:63] **8:85**-3.7.

i. - iii. (No change.)

(b)-(d) (No change.)

[10:63]**8:85**-3.13 Moveable equipment

(a) (No change.)

(b) The allowance per licensed bed will be determined by applying to this median cost the applicable interest rate developed per N.J.A.C. [10:63]**8:85**-3.11(f).

(c) Inasmuch as this allowance will be based upon the current replacement cost of new equipment, it will be deemed to provide for unusually large expenditures for maintaining old equipment (the [departments consider] **Department considers** it to be purely a management prerogative as to when to replace, rather than repair, old equipment). [A] **Effective with rates implemented on or after July 1, 2000, a** provision for ongoing routine equipment maintenance and replacements will not be included in the maintenance and replacements allowance as described in N.J.A.C. [10:63] **8:85**-3.14.

[10:63]**8:85**-3.14 Maintenance and replacements

(a) An allowance for the maintenance of land, land improvements, building and building equipment and for replacement of building equipment will be developed for Class I and Class II facilities and each type of Class III facility as follows:

1. – 5. (No change.)

6. Each NF's maximum total allowance per reasonable plant square foot for any one year will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. [10:63] **8:85**-3.7(a)1, 2 and 3.

i. For Class III NFs which are approved as a combination of Ventilator/ Respirator type and some other SCNF type listed at N.J.A.C. [10:63] **8:85**-3.3(a)3ii, the reasonable limit for maintenance and replacements will be determined by multiplying the current costs of maintenance and replacement attributable to each type of SCNF patient times the respective cost per square foot maintenance and replacement cost limits. The products will be totaled, and then divided by the total current cost of maintenance and replacement expenses. The resulting combined cost limit will then be multiplied by the reasonable long term care square feet of the SCNF to determine the maintenance and replacement screen.

	(1) Cost	(2) Limit Per square foot	(3) Total (1) x (2)
Vent	A	C	E
Other	B	D	F
Total	G		H

Weighted limit per square foot = H/G
Total reasonable limit = Weighted limit x Square feet

7. – 8. (No change.)

[10:63]**8:85**-3.15 Property insurance

(a) An allowance for property insurance will be developed for each home as follows:

1. - 2. (No change.)

3. The procedures described in N.J.A.C. [10:63] **8:85**-3.14 will be used to eliminate extremes and to develop the formula to be used to calculate the reasonableness limit for property insurance, except for the calculation of Class III limits.

4. Each NF's reasonableness limit per reasonable plant square foot will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. [10:63] **8:85**-3.7(a) 1 and 2.

Recodify existing N.J.A.C. 10:63-3.16 and 3.17 as **8:85-3.16 and 3.17** (No change in text.)

[10:63]**8:85**-3.18 Adjustments to base period data

(a) As described elsewhere in this subchapter, with the exception of capital items, rates will be based upon reasonable actual base period costs. This section provides for adjustments to reasonable base period costs in establishing prospective rates.

1. - 2. (No change.)

3. With respect to requests for management changes, the [departments] **Department** will take the position that it is not a prerogative of a rate setting body to unilaterally make or amend social policies, especially with respect to the appropriateness of current allocations of State resources to the care of indigent NF patients. Accordingly, in the absence of other compelling reasons, management changes will be approved only in areas where quality has been found to be marginal by health facility inspection and actual costs are commensurately low.

4. (No change.)

5. In the case of significant items, the [departments] **Department** may exclude the effects of legal and management changes from rates until the change is effected, and, if necessary, new appraisals made.

[10:63]**8:85**-3.19 Inflation

(a) (No change.)

(b) This inflation factor will be developed by the [Division of Medical Assistance and Health Services and the Department of Health, Health Facilities Rate Setting] **Department**.

(c)-(e) (No change.)

(f) No provision for inflation will be made with respect to costs for buildings, land, moveable equipment, interest and lease, as determined by N.J.A.C. [10:63] **8:85**-3.11, 3.12 and 3.13 nor to special amortization of capital costs as determined by N.J.A.C. [10:63] **8:85**-3.8.

[10:63]**8:85**-3.20 (No change in text.)

[10:63] **8:85**-3.21 Appeals process

(a) When a NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of N.J.A.C. [10:63]**8:85**-3.2(f)), two levels of appeals are available: a Level I Appeal heard by representatives from the Department of Health and [Department of Human] **Senior** Services; and a Level II Appeal heard before an Administrative Law Judge.

1. Level I Appeal: A request for a Level I appeal should be submitted in writing to the Department of Health **and Senior Services**, [Health Facilities] **Nursing Facility** Rate Setting **and Reimbursement**, [Health and Agriculture Building, Room 600, John Fitch Plaza, CN-360,] **P.O. Box 715** Trenton, New Jersey, 08625.

[i. Requests for Level I appeals shall be submitted in writing within 20 calendar days of receipt of notification of the rate by the facility.

ii. A facility shall identify its rate appeal issues in writing to the Department of Health, Facilities Rate Setting, within 50 calendar days of receipt of notification of the rate by the facility.

iii. Documentation supporting the appealed rate issues shall be submitted to the Department of Health, Facilities Rate Setting, within 80 calendar days of receipt of notification of the rate by the facility.

iv. The first level of appeal will be heard by analysts from the Department of Health and supervisory-level representatives from both the Department of Health and the Department of Human Services, as required. NFs should be prepared to provide such substantiating material as may be required for an informal discussion of the subject matter.

v. Level I appeals will endeavor to reach equitable resolutions of matters peculiar to individual NFs. They will not be expected to resolve items which have policy implications or broad applicability.

vi. The analyst's recommended resolutions will first be reviewed at appropriate levels within the Department of Health, Health Facilities Rate Setting, and will then be forwarded to the Division of Medical Assistance

and Health Services for the approval of the Director or a designee of the Director.]

i. Requests for Level I appeals shall be submitted in writing within 60 days of the receipt of notification of the rate by the facility and shall include as follows:

(1) A letter requesting a Level I appeal from the facility and/or from the facility's designated representative;

(2) A specific description of each appeal issue; and

(3) Appropriate documentation that will be sufficient for the Department to understand the nature of each issue of the appeal. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

[vii]**ii**. Adjustments resulting from the Level I appeal **submitted in accordance with (a)1i above** shall be effective as follows:

(1) At the beginning of the prospective reimbursement period if **either** an error in computation was made by the Department or [if] the appeal was submitted within the specified period.

(2) On the first **day** of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

[viii.]**iii.** The date of submission shall be defined as the date received by the Department of Health **and Senior Services**.

2. Level II Appeal (Administrative Law Appeal): If the NF is not satisfied with the results of the Level I Appeal, It may request a hearing before an Administrative Law Judge. **No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.**

i. Request for an administrative hearing must be submitted in writing to the New Jersey State Department of Health **and Senior Services**, Health Facilities **Nursing Facility** Rate Setting **and Reimbursement**, [Health and Agriculture Building, Room 600, John Fitch Plaza, CN 360] **P.O. Box 715**, Trenton, New Jersey 08625.

ii. [In accordance with N.J.A.C. 10:49-5.3(a), requests] **Requests** for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level I appeal.

iii. (No change.)

iv. At the Administrative hearing the burden is upon the NF to demonstrate entitlement to cost adjustments under CARE Guidelines (Cost Accounting and Rate Evaluation System). A complete set of CARE Guidelines may be obtained from: New Jersey State Department of Health **and Senior Services**, [Health Facilities] **Nursing Facility** Rate Setting **and Reimbursement**, [Health and Agriculture Building, Room 600, John Fitch Plaza, CN 360]**P.O. Box 715**, Trenton, New Jersey 08625.]

SUBCHAPTER 4. AUDIT

[10:63]**8:85**-4.1 Audit cycle

(a) Any cost [study] **report** submitted by a Medicaid participating nursing facility (NF) which is selected for audit on or after February 7, 1983 may be audited within three years of the due date of the cost report or the date it is filed, whichever is later. This requirement shall be satisfied if the on-site audit of the NF is initiated within the three-

year period and completed within a reasonable time thereafter. If a NF audit is not initiated within this time limit, the appropriate cost [study] **report** or cost [studies] **reports** shall be excluded from the audit, subject to the conditions set forth in the balance of this subsection and the waiver provisions set forth in (b) below. Exclusion is subject to the following conditions:

1. Failure to initiate a timely audit shall not preclude the [Division] **Department** from collecting overpayments, interest or other penalties if the overpayments are identified by an agency other than the [Division] **Department.**

2. When a timely audit is conducted and additional overpayments are discovered by another agency, the [Division] **Department** shall not be precluded from collecting such overpayments together with any applicable interest or other penalties.

(b) The [Division] **Department** shall not be precluded from waiving the three-year limitation for good cause, and good cause shall include, but not be limited to, the following circumstances:

1 - 2. (No change.)

3. The [Division] **Department** could not have reasonably discovered by audit any evidence of the overpayment within the three-year period;

4. (No change.)

(c) Notice must be given to the NF when the three year requirement is waived together with the reasons for such action. The NF may request a hearing on any waiver by the [Division] **Department** to the extent authorized by applicable statutes, rules and regulations.

[10:63]**8:85**-4.2 Audits

(a) For the exclusive purpose of calculating interest, under N.J.S.A. 30:4D-17(f), "completion of the field audit" for nursing facility providers shall be defined in the following manner:

1. (No change.)

2. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the **Division of Medical Assistance and Health Services (DMAHS),** Office of Program Integrity Administration (OPIA) **,** receives authorization to take administrative action.

3. (No change.)

(b) - (d) (No change.)

[10:63]**8:85**-4.3 Final audited rate calculation

(a) The [Division of Medical Assistance and Health Services] **Department** will calculate final per diem rates based on audit adjustment reports.

(b) - (c) (No change.)

(d) The basis for establishing guidelines for the prospective per diem rates, and costs which may be reported, are the CARE (Cost Accounting and Rate Evaluation System) Guidelines which appear at N.J.A.C. [10:63] **8:85**-3.

(e) (No change.)

(OFFICE OF ADMINISTRATIVE LAW NOTE: The proposed new N.J.A.C. 8:85 Appendices are reproduced in regular typeface, rather than boldface.)